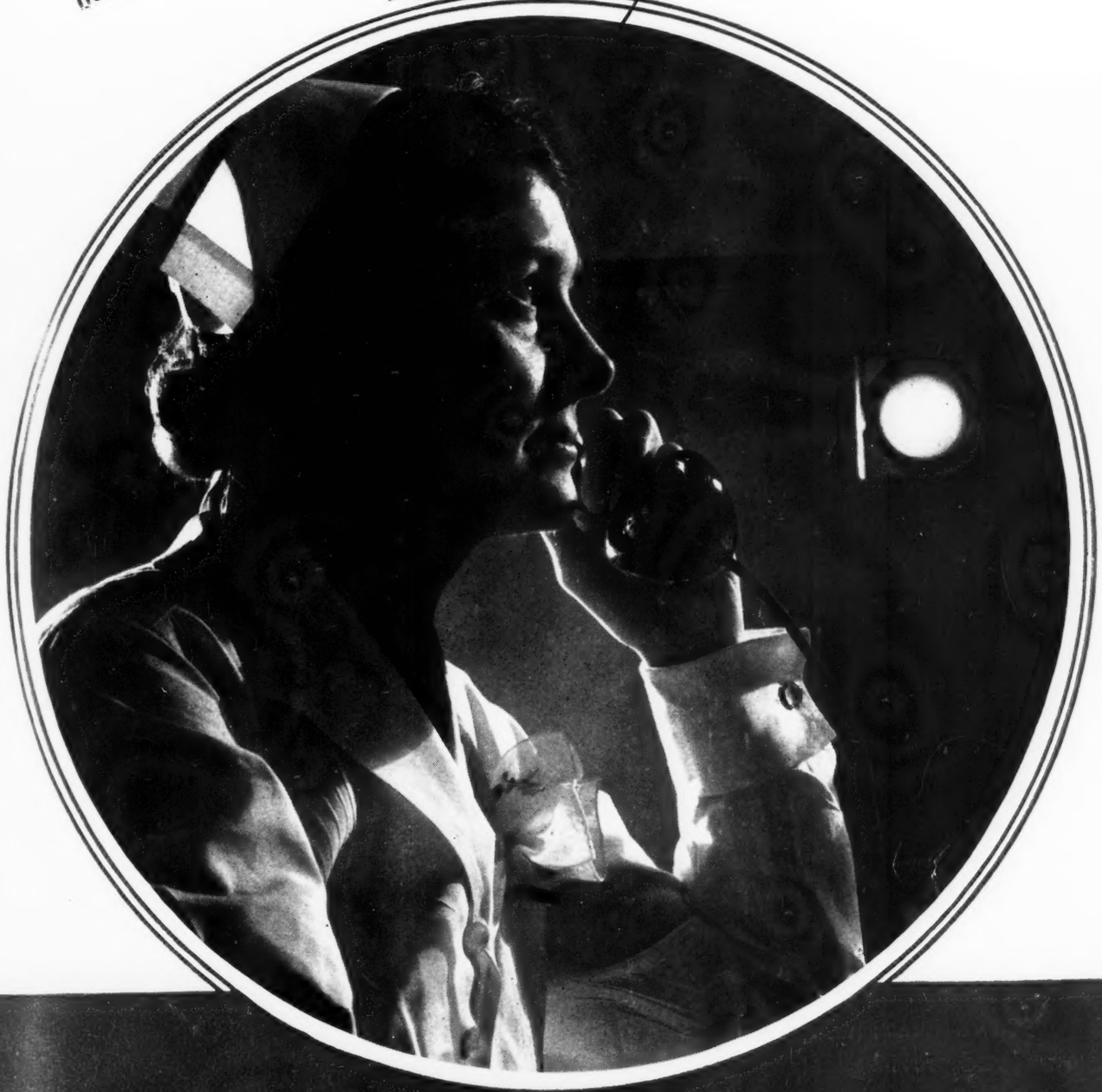

the MODERN HOSPITAL

VOLUME 67 SEPTEMBER 1946 NUMBER 3

For the Restaurant and Institutional Field

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OCT. 7TH TO 13TH

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THE ROVING REPORTER

Workshop for Canners

Those who read L. Gene Sando's fine article, "Feeding the Mentally Ill," in the July issue on regard to coordinating farm and dietary projects for Ohio state institutions will be interested in the Food Preservation Workshop sponsored by the New York State Department of Mental Hygiene in late June. The workshop was a three day affair held at Rochester State Hospital and it attracted many authorities on the processing and canning of foods.

Dr. Frederick MacCurdy, the state commissioner, recently requested the U. S. Department of Agriculture to send an authority to survey the canning facilities at 19 of the state mental hospitals. The recommendations were for more modern equipment and an adequate staff at the food preservation centers.

The workshop had as its purpose the raising of the quality of processed foods at the institutions as a direct contribution to a better feeding program. The nutritional aspects of canned foods and new developments in canning procedures and practices were discussed and demonstrated.

Sans Golden Slippers

You and I might not agree on what constitutes heaven but there is a surprisingly general agreement on this topic at Thieme Gardens on Miller Road 2 miles west of Fort Wayne, Ind.

A lot of old people are newly settled there in a house that might be in a more appropriate setting on the Italian Riviera although if it had a view of the Mediterranean the chances are it wouldn't have five bathrooms in ratio to the 13 other rooms.

This mansion is set in a 13 acre private park and the old people have the run of the grounds. If you had been denied or begrudged a bed in a local hospital or been parked for some time on a surly grandson-in-law, you might recognize heaven when you saw it in the form of the beautiful George Thieme estate. This estate now operates under the name of Lutheran Hospital Convalescent Home. The home was dedicated on June 23 and it serves convalescents and the aged both.

Mr. and Mrs. Thieme left furniture, draperies, rugs, paintings and sculpture in the house and these take the institutional curse off the hospital beds, bedside tables and the customary professional equipment.

Each room is a room with a view, besides having a high ceiling, cross ventilation and oil heat. A small farm goes with the property bringing the total acreage to 43.

E. C. Moeller, superintendent of Lutheran Hospital at Fort Wayne, reports that a registered nurse serves as matron and supervisor of nurses at the home and that, besides comfort and beauty and good meals, there is an atmosphere of love and kindness.

What more could you ask of heaven—golden slippers?

"Dietary Headaches"

Try something light like the following in your hospital house organ. The chances for reducing both petty thievery and complaints would seem brighter than if you dished your advice out straight. For this we are indebted to Juanita Cochran and *Hospital News* of Charleston General Hospital, Charleston, W. Va.

"Though our silverware isn't silver, it still costs money and every time you borrow some—yes, just one little spoon—it means added expense. Cups, glasses and other dishes don't come as premiums with oatmeal either.

"Salt and pepper shakers are the best souvenirs, especially the small ones that fit into a pocket, but even with the present increased postwar production everyone cannot have a supply—just a thought, of course.

"One and all are welcome in the staff dining room and we are terribly sorry that guests cannot be accommodated. So

if your proud parents or redheaded stepchild should drop in to see you, couldn't you please—maybe, take them to 'The Corner' or some place for nourishment?

"Too bad we can't get enough of that wonderful stuff but 'butter days' are surely ahead, and if wishes were cattle, you could have more meat to eat. It is all too obvious that the food situation looks more hopeless, less delicious and more or less of everything each day—but don't give up.

"To give you some idea, the cost per meal follows:

$ 30.00	To serve ice cream.
110.00	To serve chicken.
32.00	For pineapple upside-down cake.
24.00	To serve baked ham.
20.00	To serve peas.
15.75	For green beans.
37.50	To serve strawberries with whipped cream.
18.00	To serve lunch meat.
19.00	For cantaloupe.
45.00	To serve fish, with no extra charge for the smell.

"Last month our dairy bill was $458.22 for our pediatric department alone, and our 'egg man' gets a check for $125 to $175 each week.

"Just one last remark—don't ever stop griping about the food; it proves that you are still normal and it is good to hear you say, 'I hate lamb' and 'Where in &=?%* is all the "culiflower" comin' from?' You can say it and be glad you did."

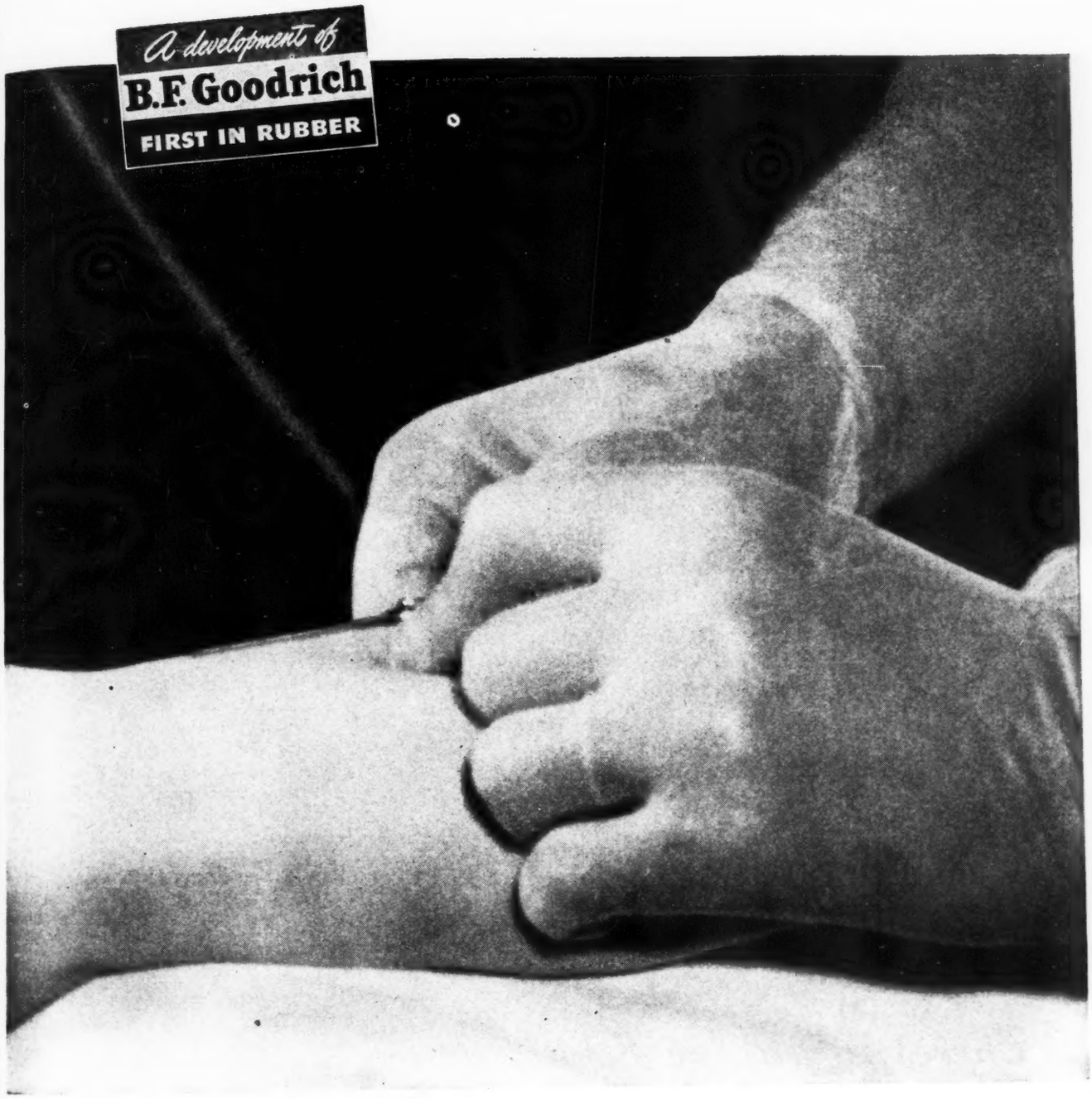
They Eat What They Pay for

Beween afternoon and evening sessions at the recent personnel institute for hospital administrators in Chicago, six or eight administrators of the institute faculty were sitting around relaxing and, as usual, talking shop. The group was representative of hospitals in the South, East and Middle West, pretty good sized hospitals, for the most part.

The talk turned to feeding employes. At one of the hospitals represented, a switch had recently been made from part maintenance to full cash payment of salaries; employes were now paying cash for meals taken at the hospital dining room.

"It's really miraculous how food waste has diminished under the new arrangement," the administrator of this hospital remarked. "Formerly, when we were providing meals as part of our employes' compensation, they'd come into the dining room and accept servings of everything, even when they didn't feel like eating. Then they might take a few nibbles from the plate, and sprinkle cigaret ashes on the food, or even crush out cigarets in the mashed potatoes. Certainly the amount of waste was terrific. I guess they figured they were paying for the meals anyway so it didn't make any difference what happened to the food.

"All that is changed now. Employes don't buy meals that they aren't going to eat. Our kitchen maids report that



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B.F.Goodrich

RUBBER *and* SYNTHETIC *products*

plates coming from the employes' dining room are generally clean as a whistle these days."

"That's about the experience we had when we switched over," observed another, "and, actually, everybody gains. We serve the meals to our employes at cost, and we figured them at cost when they were included as compensation, so the employes come out even. And we gain by saving the waste that was bound to take place under the old arrangement. I suppose it's just human nature to be careless that way with food, or anything else, that we don't pay for piece by piece."

"Another thing," a third administrator added, "is that our people seem to like the freedom of choice they get on an all cash basis. Mostly they take their meals at the hospital, just as they did before, but the fact that they can eat out if they want to, or bring their lunches with them, seems to mean a lot."

One man wanted to know then what the practice was in providing dining space for various classifications of employes.

"We keep 'em apart," was the first answer. "Nurses and laboratory technicians generally don't want to sit down at the same table, or even in the same room, with maids in spotty uniforms or maintenance men in greasy overalls."

"Yes, but if you separate them like that, one group will always complain that it isn't getting as good food as the other," someone said quickly.

"That's right," another agreed. "Even if you show them that they're getting the same dishes, from the same kitchen, they're likely to think it's served differently or that they get smaller portions, or something. Fact is, they resent being segregated."

"I wouldn't want to separate them anyway," one administrator argued. "We've got one big dining room for everybody, including the doctors, and it works out fine. I never heard anybody complain about maids or maintenance men being there. As a matter of fact, when you give them the opportunity to eat in a big dining room with the doctors and nurses, they tidy up before they come to meals. The maintenance men always wash and put on a clean shirt or jacket. I think it's good for the whole institution not to have these sharp lines of distinction."

"But what if you have colored help?" someone asked.

"We do, and they're right there in the same dining room!"

"You can't do that in the South!" was the swift retort. And the talk flowed on and on, until someone noticed that it was time to go back to the institute classrooms and teach personnel methods to the students.

Blue Cross Shows the Way

Hospital administrators wrestling with salary and wage problems—and that takes in about all of them—will want to know about the thoroughgoing piece of work done by Associated Hospital Service, Inc., the Wisconsin Blue Cross plan.

Its board of directors recently adopted a job description and salary schedule for the 115 full time and 10 part time employes of the plan.

In an effort to provide equal pay for equal work, L. R. Wheeler and his committee set up several specific objectives and then went systematically about realizing them. The steps taken by the committee were:

1. Formulation of concise and accurate descriptions of work done by each employe (written on a form supplied to the employe and checked by the department head).
2. Classification of employes into appropriate work levels or groups.
3. Establishment of the relative value of each group.
4. Advancement of merit as the basis for pay and promotion.
5. Determination of average salary standards with limits for each work level or group.

6. Apprehension of unusual situations or conditions outside of the schedule.

It was a big job and a long one but now it's done and the organization has a systematic plan for administering salaries and promotions, two vital factors in personnel management.

Ditto for Sr. Bernadette

If our 7AA flexible feet could take it—"flexible" is easier on the self esteem than "flat"—we should like to enroll as a student nurse on the understanding that Sr. Bernadette Armiger would be our clinical instructor.

Sr. Bernadette makes bedside clinics, clinical conferences, nursing care conferences, demonstrations — yes, even "evaluations" (a politer word than "tests") sound too fascinating to miss.

To get Sr. Bernadette, you have to go to the Catholic University of America School of Nursing, Washington, D. C. In case, like us, you can't get in because of flexible feet or an inflexible head, you can at least read what she says about clinical teaching in those bulletins for schools of nursing that the Catholic University gets out four times a year.

We think they're swell. Ditto for Sr. Bernadette.

A King Goes Begging

When Carl Flath gets to his new post in Honolulu and starts soliciting funds to carry on the expansion program contemplated, he'll find royal precedent for begging from door to door.

There would never have been a Queen's Hospital for G. W. Olson or Carl Flath to administer if it hadn't been for King Kamehameha IV.

Like many legislators in 1946, the Hawaiian lawmakers of 1859 had really pressing matters to consider, such as levying taxes on jackasses and deciding who should be allowed to sell liquor. They gave the old run-around to the king's plea for funds to start a hospital for the poor.

So out in the pouring rain or hot sun, the 25 year old king went up and down on foot begging money in homes and offices and on street corners. After many hours a day spent soliciting hospital donations, the *Polynesian,* the town tattler of that day, picked up the story and right then the king's pressure politics started to pay off.

When the legislators made inquiry, they found that Kamehameha IV had gathered $13,000, mostly in small change, for founding a hospital.

Along about 1860, the king and his queen got their hospital, the legislature having added some kingdom money to the king's fund.

They're Hiding on Campus

If you are wondering where all those nurses are that marched off to war and left you training volunteers and pinch-hitting with practicals, there is one spot you may not have searched.

That is the college campus. These brave gals are entitled to more education under the G.I. Bill of Rights and many of them would be silly if they passed up such an opportunity even if you and the patients do need them.

Edna Peterson, superintendent of nurses at the Jewish Hospital of St. Louis, says her office force has been spending about two days out of every recent week filling out forms required by V.A. and by the universities for these nurse veterans. Presumably other schools are having the same experience.

Once they get their graduate training, will these nurses come back to the hospitals? Not all of them, certainly, for many are enrolled for graduate work in public health nursing. Others are headed for doctors' offices or industrial work or marriage. But many of them should be back, not necessarily to the hospitals they left to go to war but to some hospital post—provided hours and salaries and living conditions are to their liking. It's something for the hospitals to study while the girls are at study.

READER OPINION

Good Idea

Sirs:

I read a very interesting and timely article in your July issue regarding "Feeding the Mentally Ill" in Ohio state institutions. And now, how about a fine article by someone calling for the *healing* of the mentally ill in Ohio state institutions? Most people in Ohio state hospitals are in there just for custody. If given medical treatment many can be restored to health. I saw many fine young persons there; they deserve a better chance.

W. A. Simmons

Baltimore

Labor Relations

Sirs:

Your article on personnel relations in the July issue ["Lessons in Labor Relations," by Bachmeyer, Gorgas and Mills] was greatly appreciated. We agree with the authors, especially in the matter of labor relations.

Karl P. Meister
Executive Secretary
Board of Methodist Hospitals and Homes
Chicago

Editorial Board

Sirs:

In reading this month's issue I chanced to look over the names of the editorial board and the various subdivisions, such as administration, finance, hospital service and so on.

It has occurred to me that owing to the increased interest of the profession in group practice it would be well for your magazine to consider a subdivision with particular emphasis on this subject. It appears that it will grow in importance as the readjustment from wartime activities takes place.

A. G. Howell
Administrator
Raiford Memorial Hospital
Franklin, Va.

Wristwatches at Montefiore

Sirs:

We do not have a Quarter Century Service Club as they are fortunate to have at Mount Sinai Hospital in Cleveland ["The Roving Reporter," July 1946] but if your readers are interested in such matters, personnel practices being of the greatest importance these days, they may want to know that our board of trustees has awarded precious wristwatches, appropriately inscribed, to eight employes who have rounded out twenty-five years of service in our hospital during the last twelve months. We are glad to have the pin idea and may adopt that method, too, before long.

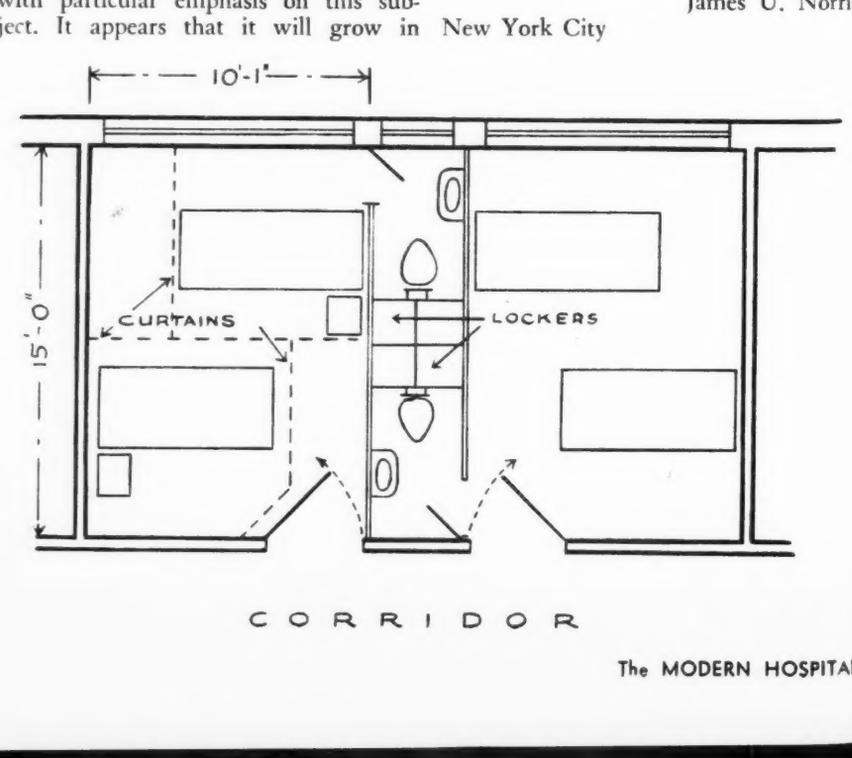
Louis Slatin
Personnel Executive
Montefiore Hospital
New York City

Two Bed Rooms

Sirs:

The enclosed plan (see acompanying sketch) meets the principal objection to other two bed arrangements ["Two Beds Add Up to Many Problems," The MODERN HOSPITAL, May 1946] in that it allows the outer bed to be curtained off without depriving the occupant of the inner bed of light and air. It also premits the placing of the wash basin within the toilet room instead of outside in the patients' room.

James U. Norris
New York City



SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Detroit Medical Hospital, Detroit, Michigan: Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Collections Should Be Tactful

Question: Is it good public relations to employ a collection agency for past due accounts?—R.S., Ind.

ANSWER: There is no particular objection to the employment of a collection agency, from a public relations standpoint, provided its methods have been investigated and the extent to which pressure should be brought to collect the amount due has been defined.

If the hospital, through its own efforts, has given the patient sufficient time to pay the account, measured in terms of his ability to liquidate it, there is no good reason why a collection agency should not be used if the patient has not kept the agreement.

In a smaller community in which the financial habits of individuals are better known, the hospital might hesitate to use a collection agency, but I'm sure the public in general expects people to pay their just debts. The largest benefactors of hospitals are businessmen who have had to meet the same problem in their own business.

If care is exercised and if each account is considered individually before resorting to a collection agency, the public relations of the hospital should not be impaired. Keep in mind the net amount that will be received if the agency is able to collect the item in full and determine whether it is really worthwhile, especially on accounts with small balances. It is often far better to write off the whole account, using the reserve that has been set up for this purpose.—LESLIE REID.

Amount of Laundry per Bed

Question: What should be the daily laundry allotment for each private, semiprivate and ward bed?—M.A.T., Mich.

ANSWER: The daily laundry allotment for private, semiprivate and ward beds should provide for a daily change of all linen. During these times of acute shortage in bed linens it perhaps is wise to stagger the changes of bed linen for ambulatory ward and semiprivate patients, although this is a step to be taken with reluctance. Nothing is so good a morale builder for the patient as a clean, fresh bed and its therapeutic value should be kept in mind when considering linen and laundry costs.—WILLIAM J. DONNELLY.

Allowance for "Living Out"

Question: What is the trend in granting "living out" allowances?—M.T., Conn.

ANSWER: The trend in the payment of employes for their services is to quote the salary on a gross basis and if the employe then decides to purchase any meals, laundry or room accommodations, these should be shown as deductions. This is much the same thing as saying that "living out" allowances should be made, except that from a psychological standpoint it is better to let the employe know what his total earnings are and be given the option of buying only those services in which he is interested.

Hospitals should be, and are, getting away from the old practice of quoting a salary plus a certain amount of perquisites. Quoting gross salaries puts all applicants on the same basis.—LESLIE REID.

Are Hospitals to Blame?

Question: 1. Does the public blame hospitals when it cannot obtain care for the chronically ill in hospitals? 2. What percentage of the chronic disease patients would benefit from hospital care?—R.W.C., Ohio.

ANSWER: 1. The extent to which the public blames the hospital when it refuses to admit or keep long term patients depends considerably upon the way in which the hospital deals with individual cases and with its community responsibilities. The public rightfully looks to hospitals for help in meeting problems of caring for the sick. If the hospital feels no responsibility for helping individuals, and the community as a whole, to meet the urgent problems involved in obtaining care for long term patients, the public will feel that it is failing in its obligations to the community.

On the other hand, if the hospital is meeting its responsibilities for helping to keep the public informed of the need for more and better facilities for care of these patients and is actively participating in community efforts to develop them, it is not likely to be seriously criticized for its own inability to provide the care.

2. If no patient were admitted to a home for the chronically ill or accepted as a permanent invalid in his own home without first having had a good period of diagnostic study and as much treatment as indicated in a hospital, a great deal of the present burden of invalidism could be prevented or relieved. The appalling lack of such attention for long term patients is one of the most serious inadequacies in their care at the present time. Far too many patients, especially in the middle and older age groups, are accepted as permanent invalids without any real effort to improve their physical condition or check the development of further disabilities.

Since the duration of the patient's need for the specialized services of the hospital is usually much shorter than the total period of disability, it is probable that the number of hospital beds needed for the care of these patients is somewhat less than the number needed in homes for long term patients. Boas has estimated that approximately three beds are needed in homes to one in the hospital. Bluestone might set the figure higher.

Probably no really accurate figure can be determined until there has been more experience in actually giving such care to patients and observing the results. There can be no question, however, that many patients not now receiving such care could profit from it.—EDNA NICHOLSON.

Treat All Alike

Question: Must personnel practices be the same for the entire organization? Are holidays ever allowed nursing personnel?—R.B.A., Wis.

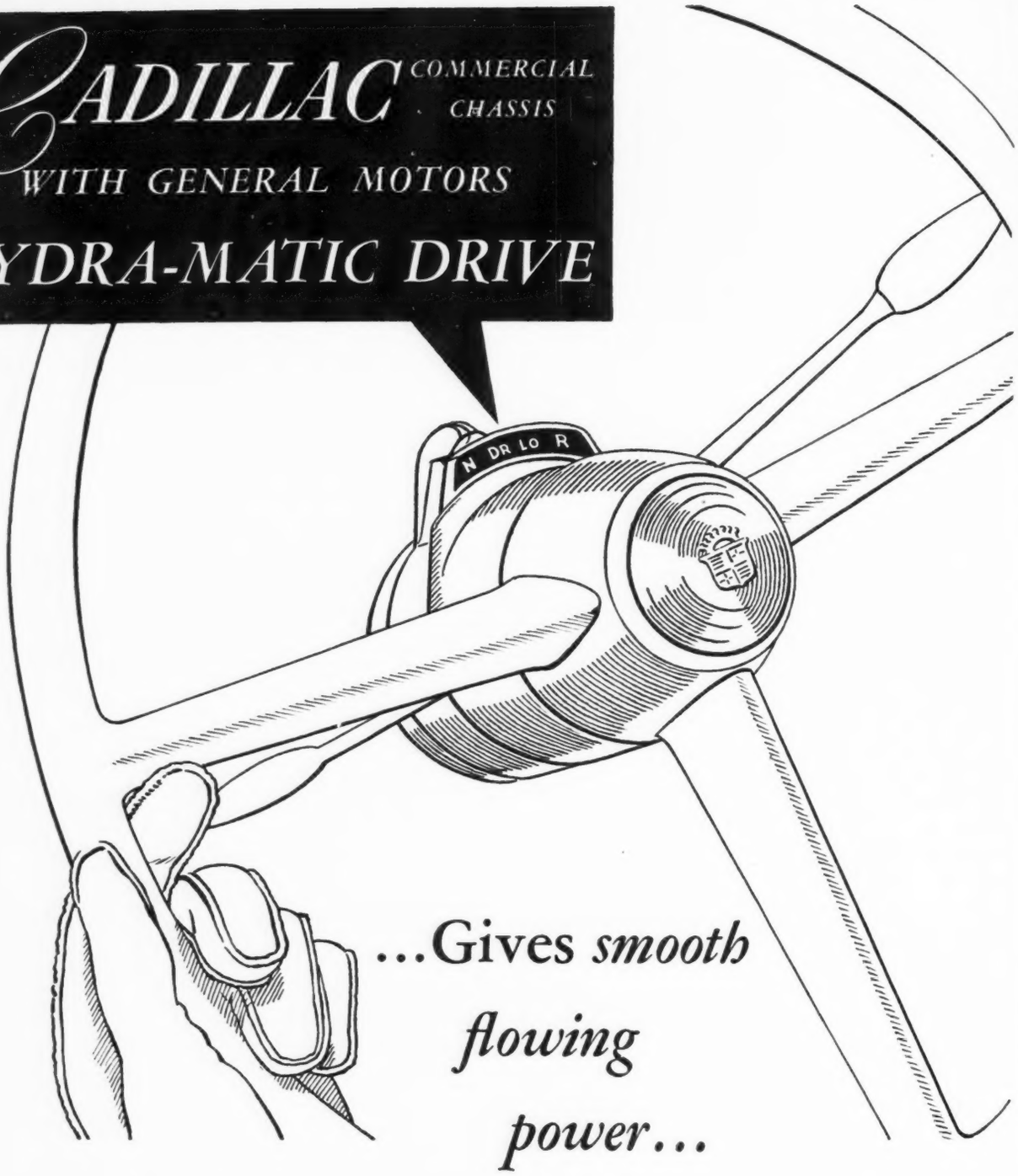
ANSWER: Personnel practices should at all times be fair and equitable for all. There is no reason why some employes should be allowed holidays while others are deprived of them. If certain members of the staff, such as those in the nursing department, cannot be spared on the holiday, they should be given a day off to compensate for it. They will feel much better if allowed to choose the day which may be in conjunction with their next day off or at some other desirable time.—GRAHAM F. STEPHENS.

Charges for Guest Trays

Question: Do you serve guest trays; if so, at what charge?—J.C., Minn.

ANSWER: Yes, we do serve guest trays upon request, at a charge of 25 cents for breakfast, 50 cents for dinner and 35 cents for supper or lunch. On some Sundays we charge 75 cents for dinner. —GERTRUDE LINN SAWYER, R.N.

CADILLAC COMMERCIAL CHASSIS WITH GENERAL MOTORS HYDRA-MATIC DRIVE



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LOOKING FORWARD

Shabby Tactics

WITH hospital building programs of unprecedented volume in prospect, building fund campaigns are at fever heat all over the country. Hospital administrators and trustees are throwing themselves into campaign work enthusiastically, burning with zeal to put their drives over the top.

Sometimes, however, their enthusiasm outruns good judgment; occasionally it even reaches the boundaries of acceptable business ethics. Here and there, it is reported, administrators are putting the bite on hospital suppliers for campaign contributions. In fact, one manufacturer tells of receiving a letter frankly requesting a donation and reminding him pointedly that the expanded hospital contemplated in the fund raising drive could buy larger quantities of his product.

These are shabby tactics. The implied threat that future business relations may depend upon a donation is upsetting to the supplier, who naturally does not want to jeopardize his standing with any hospital but, plainly, cannot possibly contribute to all the hospitals to which he sells. Other implications of this blackjack method of seeking gifts for hospitals are equally unwholesome. For example, what would patients think of a hospital if they knew the supplies and equipment needed for their care had been purchased in consideration of campaign contributions, instead of according to quality? What would the community think?

Moreover, as any thoughtful person can see, if this practice became general suppliers would have to consider such donations as part of the cost of doing business, and they would soon be reflected in the price of materials purchased by hospitals. As one supplier points out, he is happy to contribute to the hospital in the community where his plant is located and most of his employes live, but he contributes as a citizen, not as a manufacturer, and he does not think his firm should be called on to give to hospital campaigns all over the country.

Unquestionably, administrators and trustees who have solicited gifts from suppliers in this fashion have not done so, for the most part, with any thought that they were applying pressure. Rather, they have sought only to capitalize on the good will of business friends for the good of the hospital, without realizing that the appeal might have decidedly coercive implications for its recipient.

The evidence that such implications are found, whether they are intended or not, is abundant, and the practice is economically unsound. Donations should be sought from the community that is going to use the hospital, and only from that community. Twisting the arm of hospital suppliers for campaign contributions should be stopped right away.

Bad Business

FOR years, hospitals got away with sloppy business methods because they were thought of as humanitarian and charitable rather than as business institutions. Preoccupation with budgets, costs and other business procedures was considered *infra dig* in hospital circles; that was clerk's work. Bills were paid when money came to hand. If there was anything left at the end of the year, that was lucky; if there wasn't, it was charity.

The modern view, of course, is that efficient operation is foremost among the obligations of humanitarian and charitable institutions, including hospitals, and efficient operation is impossible without modern accounting and business methods. In many hospitals today, business methods compare favorably with the most up to date practice. But in a shockingly large number of hospitals there has been no change. Pants pocket accounting is still the rule rather than the exception in hospitals.

In 1946, for example, it is possible for the report of a hospital survey in one of the nation's great metropolitan centers to include this statement: "Many hospitals are without any accurate knowledge of their operating costs as a whole, and very few can give any cost accounting

data concerning the expense of operating individual departments or services."

It is hard to see how any hospital can justify its operation today in the absence of precise, comprehensive cost records. The uproar over Blue Cross payments could be resolved quickly, for one thing, if every member hospital could present indisputable evidence defining the costs of service rendered to Blue Cross subscribers. Too, requests for badly needed higher rates from government agencies look silly when hospitals cannot say plainly, "This is what we spend caring for indigent patients, and this is how we spend it." Even campaigns for community contributions lack strength and authority when hospitals cannot demonstrate wise, economical stewardship of community resources. Finally, patients and their families are reassured when the many business transactions incident to hospitalization are handled with the kind of smooth efficiency that reflects good accounting and business methods.

Such methods are within reach of every hospital in the country today. For the larger hospital, trained accounting personnel costs money, but trained people also save money and improve service. For smaller hospitals, where business details must be handled by the administrator or, at best, a general office assistant, many aids are available. The American Hospital Association furnishes an excellent manual of hospital accounting; there are institutes on accounting designed explicitly to meet the needs of these people; nearly all colleges and universities now offer extension courses in accounting and business methods.

The hospital which persists in sticking to old fashioned and inadequate methods is hurting itself, its patients and its community. There ought to be a law.

Nice Work!

WHEN President Truman signed the federal Hospital Survey and Construction Act on August 13, a new era in hospital planning was ushered in. Construction of hospitals at the whim of philanthropists or enthusiastic but uninformed community leaders is now definitely out of date. Guided by the new law, construction according to need will become the rule.

Thus every hospital owes a debt of gratitude to officers of the American Hospital Association and the U. S. Public Health Service and other hospital and medical leaders who took part in the preparation and passage of this useful legislation. With great wisdom and patience, these men helped to draft the bill and reconcile the diverse views of many interested but widely separated groups. They guided it then through weeks and months of exhaustive hearings, protecting the public interest against raids by politically minded chiselers. Finally, they steered it through the maze of committee and conference approvals and other procedures that are part of our federal lawmaking machinery.

The law will help immeasurably to get hospital facilities built where hospital facilities are needed and to keep them from being built where they are not needed. To aid the accomplishment of these worthwhile objectives, which benefit all hospitals, it becomes more than ever the duty of hospitals to cooperate with state groups in completing the hospital surveys and to work diligently together toward effecting suitable hospital licensing legislation in all states.

Labor Relations

IN THIS issue, The MODERN HOSPITAL presents a round table discussion of nurses' unions and the third of a series of articles on labor relations, this one dealing with the technics of collective bargaining. At the recent personnel institute for hospital administrators in Chicago, labor problems claimed a major share of attention.

These are signs of the times, possibly prophetic of a day when formal negotiations between management and unions may be the accepted method of determining wages, hours and working conditions in hospitals, as they are already in so many industries. Observers may disagree as to whether or not that day will ever come, or how far off it is, but few will doubt the wisdom of hospital administrators who are starting now to learn the basic principles of labor relations. Reading these articles is a good way to begin.

Public Relations Job

AS THEY always do in times when people have money, the health rackets are flourishing. The patent medicine peddler has replaced his frock coat with a white jacket, and he may operate from a radio station instead of from the tailboard of a wagon, but he is still handing out the same old hokum. The only difference is that by using modern technics, the latter-day medicine man reaches thousands of people instead of only a few.

It is an astonishing fact, too, that these rackets prosper, not only among the poor and ignorant but also among educated and supposedly intelligent people. A recently exposed fraud was found to have been operating from the very best hotels, selling a useless system of exercises to high-priced business executives at $100 a head! Another charlatan sold a spine-stretching device to cure rheumatism, getting $125 for a rig that cost possibly $5 to make.

Actually, millions of dollars are spent every year on worthless tonics and remedies, quack treatments and phony health systems. Worse yet, thousands of people who are sick and need good medical care waste precious weeks or months seeking a short cut back to health along the dubious paths of quackery or patent medicines.

As responsible health agencies in the community, hospitals should join forces with the medical profession to expose and eliminate the health rackets.

Are Nurses' Unions Necessary?

Stenographer's report of a down-to-earth talk about this problem hospitals and nurses are facing today

NURSES' unions are something new in the hospital world, and something that has been talked about, for the most part, only in whispers. Among hospital groups, there has been little full, frank discussion of nurses' unions; especially, there has been little effort to include the union point of view in any discussions that have been held.

A few weeks ago, a group of hospital and nursing leaders, including a union representative, was invited to The Modern Hospital offices in Chicago to have just such a discussion. Those who took part were: Roger W. DeBusk, M.D., director of the Evanston Hospital, Evanston, Ill., and president of the Chicago Hospital Council; Maurice J. Norby, research director of the Commission on Hospital Care; Mary I. Bogardus, director of nursing at the University of Chicago Clinics and president of the Illinois State Nurses' Association, and Mrs. Emily W. Belknap, chairman of the Chicago nurses' chapter, United Public Workers, C.I.O., and graduate staff nurse at the Illinois Neuropsychiatric Institute. Also present for the discussion was Robert M. Cunningham Jr., managing editor of The Modern Hospital.

Cunningham

Belknap

Norby

DeBusk

Bogardus

So that all our readers might virtually sit in on this lively meeting, we had a stenographer in the room taking down everything that was said. In the following pages, The Modern Hospital presents a slightly condensed transcript of the stenographer's report of the discussion.—*The Editors.*

MR. CUNNINGHAM: Our discussion today is on nursing personnel problems and, particularly, the union movement that has gained recognition in various parts of the country in the past few months and is something in which all hospital people are taking great interest. Mrs. Belknap, as the representative of a union group, do you want to start by telling us a little bit about what your people are striving for and how far they have gone?

MRS. BELKNAP: If it gets too long-winded, just say when.

MR. CUNNINGHAM: We want you to give us a full discussion.

MRS. BELKNAP: Every day more nurses are joining unions. There is no mystery behind this fact. Although the nurse may derive moral and spiritual satisfaction from her work, society has shown small concern with whether or not she is able to live in decency, whether or not she is able to raise her family in comfort, whether or not she has security. Do you want to know why we join unions?

MR. CUNNINGHAM: Yes.

MRS. BELKNAP: Primarily we join unions because the unions can help our economic situation better than professional organizations. These are the fundamental reasons for joining the union: wages, hours and working conditions. Do you want specific instances?

MR. CUNNINGHAM: Yes, let's have the details.

MRS. BELKNAP: In one hospital the nurses organized almost 100 per cent to correct irregularities in personnel practices. Through the union, an agreement was reached and an honest effort was made to correct these practices. Working hours were better; there was some standardization and proper classification of wages and positions. Wage increases were obtained. Shall I go on?

MR. CUNNINGHAM: Go right ahead.

MRS. BELKNAP: In Michigan nurses joined the C.I.O. and were able to obtain many benefits that other workers in their institution already received. Salary alone was a big factor. Before union organization, nurses averaged $114 a month; when organized, they began making from $165 to $240 a month. One hospital administrator said the labor-management committee set up by the union and the hospital gave him an opportunity to explain policies and to suggest changes for more efficiency in the hospital with the staff cooperating. "Our management-labor committee has made great strides in unity of purpose and mutual development," he says.

In California and New York, nurses have organized for similar reasons.

DR. DEBUSK: I should like to ask Mrs. Belknap one question. What efforts were made by nurses who were working in these hospitals to get an adjustment in wages, hours and working conditions prior to the unionistic movement?

MRS. BELKNAP: The usual channels are gone through in the usual way with the usual result—a "run-around." It seems strange that such a simple problem as getting equal pay for equal work can often not be solved through the usual channels. It is commonplace for us to find one head nurse getting one salary and another head nurse getting another salary for the same work in the same hospital.

DR. DEBUSK: Do you think that situation obtains nationally?

MRS. BELKNAP: I think so, at least it seems so when we talk to nurses—not only union nurses; I am talking of nurses as a whole. There is a great discrepancy in salaries among nurses who are doing the same kind of work.

DR. DEBUSK: Can you define "salaries"? If you compare pay checks you find a great discrepancy. But the discrepancy is not too great if you set an evaluation on perquisites—meals, laundry, vacations and housing. What is your definition of "salary"?

MRS. BELKNAP: We agree that "salary" is total salary and includes all the things you have mentioned, but there are some aspects of total salary which we do not like. Nurses often object to this living-in, part pay and so forth. The average nurse would prefer being able to earn a salary and have a choice of whether she lives in or lives out, whether she pays for her meals or buys her meals on the outside.

MISS BOGARDUS: I think there is something we need to think of, too, when we are considering salaries. That is, it is not altogether the monthly pay check the nurse receives, but vacations and illness allowance must be taken into consideration and the arrangement of hours—whether they are straight hours of duty or divided hours. Also, whether she is given any consideration as to choice of clinical field, and if there are any plans for retirement benefits.

MR. CUNNINGHAM: Yes, that is important.

MISS BOGARDUS: And also is there an opportunity for advancement or study while on the job? Nurses are interested in all these things regardless of organization affiliation.

I wonder if we have not all been remiss—I mean hospital administrators, medical staff and nurses—in failing to get together and thus having a better understanding of a good many of these problems?

DR. DEBUSK: That is important.

MISS BOGARDUS: I sometimes feel that we approach our problem in an antagonistic way and I think we all know that that just does not go. Hospital administrators hold the purse-strings, and I know that many sincere efforts have been made to convince them of the importance of having a good quality of nursing service and a sufficient quantity of nursing service. Unless we do the things which were enumerated a moment ago we are not going to be able to provide good nursing service for patients.

MR. CUNNINGHAM: Certainly this bringing together of the people to discuss the problem dispassionately is a quite important object.

MISS BOGARDUS: Yes.

MR. CUNNINGHAM: Then here is something to talk about: First, are there other effective means of bringing these various groups together for a discussion, outside of the union? Second, is there anything the matter with doing it through unions? What is the best way to get what we all seem to agree is a desirable result?

DR. DEBUSK: We have left one thing out. To put it plainly, we are selling a commodity and we have a purchaser. We cannot leave the purchaser out. The purchaser is the general public and the general public, unfortunately, through years of training has accepted the philosophy that it is going to get a good product and it is not going to pay very much for it, and a good angel is going to come along and subsidize the deficit. The public has got to be educated to be willing to pay more for the product it is receiving, on a cost basis.

MR. CUNNINGHAM: Mr. Norby, will the public pay substantially more for hospital care than it has paid in the past?

MR. NORBY: I think the public will have to. We cannot expect the nurse to underwrite the care of hospital patients, or the other hospital employes either, starting with the superintendent and ending with the scrubwomen. All along, the salaries have been low.

Here, as Dr. DeBusk indicated, we have the public on one side profiting from the operations of the hospital. There are no individual groups in the hospital that stand to gain from its operation, except as they earn their daily wage. They do not get any surplus if there is a surplus; they do not have special bonuses voted to them; they receive no portion of the earnings of the institution.

We always get into these emotional discussions when we talk about labor and labor unions. I am all for organization; it has been demonstrated that a single voice itself is not strong enough to be heard. But it seems to me we should use the force of organization not in a coercive way, as labor discussions often develop; rather we should use the collective voice for conversation leading to better understanding of the problem.

As we educate the people about the needs of the various employed groups, that our hospital people need higher wages, what we are really saying is, "We are going to pay more for hospital care." I have not heard any complaint about hospital prices today.

MR. CUNNINGHAM: Of course, there is a limit to what hospitals can do now. Mrs. Belknap, are the unions interested in this whole business of educating the people that hospital service will cost more money?

MRS. BELKNAP: Organized labor wants the best possible hospital care regardless of cost. By belonging to labor unions we do much to inform people of problems in this field. But the thing we must do is this: We have to preach on personnel practices. In our state institutions, for example, nurses by themselves cannot get to the management. We cannot go directly to the managing officers of our hospitals to discuss these things with them. But we can go to the union, and the union can go directly to the hospital department of the state. Then they get respect and are listened to.

MR. NORBY: I would quarrel with that point of view. I don't think there is anything about the organization of the union that gives entrée to a group of people that any other type of representative could not get.

Actually, the nurses already have a union of their own, the nurses' association, and the medical fraternity has a strong, vocal association. I see no reason why the profession as a profession could not go to the groups with which it is apparently at odds and discuss these practices with them. I do not think it is degrading to a professional man to belong to the C.I.O. or the A.F. of L. I just think it is unnecessary.

MISS BOGARDUS: I wonder if you would be interested in knowing what the nurses' association has done about personnel practices? We have had a very active committee in our state association for about a year and a half. I think most people realize we must move ahead; we have been too lethargic. We circularized the 11,000 and some members of the state association, asking them to vote by mail if they were interested in having the state association represent the nurses if such questions as Mrs. Belknap has mentioned arise, and a very large majority indicated that they were interested. State associations and the national association are well aware of the fact that we have got to go ahead on this sort of thing, Mrs. Belknap. We have to establish better public relations. The public Dr. DeBusk mentions has to know the hospital and nursing picture more intimately. That will do a great deal for us. We are not vocal enough.

MRS. BELKNAP: Maybe that is the whole trouble; communication of the information is a failure.

MISS BOGARDUS: In a state association with 11,000 graduate registered nurse members, I think we ought to have a better information and public relations program. Our national association with some 181,000 members also recognizes this need.

MRS. BELKNAP: Miss Bogardus, we have a personnel practices committee for nurses in the state of Illinois. The chairman of that committee runs a hospital. She does not have time to run her hospital and the committee, too.

MISS BOGARDUS: I brought up the point to remind you that we realize the need for expansion in our state association activities.

MRS. BELKNAP: She needs to be paid by the association and not be a hospital executive. She needs to do things. Since they don't get done, the union has been the answer. We had very recently an instance when some problem was

brought to the union that was also brought to the nurses' personnel practices committee. Union activity immediately started negotiations, whereas it used to take the committee chairman almost two months to come to the hospital to find out what the problem was.

That was one case. There are many of them. The nurses want action now, not two or three or four months from now.

DR. DEBUSK: But we still have our budgets; we cannot leave our butcher and baker unpaid, and we have our public to think of, because if we raise our rates too drastically or too suddenly, that doesn't do us any good. But we can still try to adjust these conditions and do it without delay. I am talking about the voluntary hospitals. I believe it is the consensus of most hospital administrators that, given a choice, they would rather deal with the association than the union.

MR. CUNNINGHAM: Why?

DR. DEBUSK: — prejudice?

MRS. BELKNAP: I was going to ask why, too, when they have dealt with the union on important problems in the hospital.

DR. DEBUSK: Some feeling against unions is in the minds of practically all the hospitals we deal with, which is one of the reasons they would rather deal with associations. By the association I mean our own small group of nurses, engineers or any other group. I think it is true also because of the experience of some hospital people, mainly in the East and, to some extent, in the Middle West, where the bargaining agent has been a person who was not an employe of the hospital and was not even cognizant of the problems.

I want to illustrate that by some difficulties we got into with an engineering group in a hospital in the East. Honestly, the man who came out for this group of engineers was a stationary engineer in a department store, and he had not the vaguest notion what the problem was. When you can see that hospitals have to operate in the middle of the night, so Joe has to keep up the steam, you can talk sensibly about a hospital labor problem. When you can't see anything of that kind, you don't make sense at all. Does that answer your question?

MR. NORBY: Here is another thing. The power and strength that have been demonstrated by large labor organizations are such that no small operation can stand against it. The hospital administrator does not have a choice, as private industry has, of operating or not operating. You have an activity that has to go on.

So when the union comes to him and says, "You either grant these demands or we pull out the workers," it gives the employer no choice. He cannot have the workers pull out. So he has to give in to the demands.

In the nurses' assoeiation, he has a more understanding group. They have the same power. But the administrator is sure that they are not going to use it except as they use it judiciously. They know what the problem of the hospital is. It is inconceivable that a group of nurses would suddenly leave the patients they have been attending. You get a more reasonable audience, I think, dealing with professional people who know what the trouble is, than with a non-professional group interested in battling for a principle.

MRS. BELKNAP: But we do not go on strikes. That is the policy of the union. We educate. We bargain. We discuss.

MR. NORBY: Is it written into your contract?

MRS. BELKNAP: It is written into the contract. That is clear in it. What we expect the hospitals to do is to institute collective bargaining. Dr. DeBusk, you have a very wonderful hospital over there. But I had my sister in a hospital last year. The supervisor of the ward came in every day. At 7 o'clock in the morning she was on duty. She was still on duty at 9 o'clock at night. She was not a very happy person.

DR. DEBUSK: Isn't that an educational problem, education of the hospital administration and governing board, and education of the public?

MRS. BELKNAP: I am talking about nurses working in these hospitals right now, don't you see? I am talking solely about the nurse and the kind of life she is having.

MISS BOGARDUS: Wherever individuals are employed, that is extremely important, but this is also a responsibility of our professional organizations. The members should understand that we have an active program to improve personnel policies and practices. The contact that our state nurses' association has had this last year with the state hospital association is evidence of that fact. While we have not gotten them to see some things the way we would like to have them, nevertheless we have made progress in bringing about a better understanding.

MR. CUNNINGHAM: Probably that is the key to what Mrs. Belknap is talking about. Maybe there is something the union can do that gets them to see quicker.

MRS. BELKNAP: We have tried the other channels. We are able to get there quicker.

MR. CUNNINGHAM: There is something else I should like to get some expression on. Provided the union group rejects any use of coercive powers, is there still something the matter with having a union for nurses?

MR. NORBY: As I said earlier, I don't think it necessarily objectionable. I think it is unnecessary. It seems to me the experience that has been recounted here is an apparent admission that the nurses' organizations are unable or maybe unwilling to do the kind of job that some of these nurses feel necessary to be done, and so they are piling on a sort of super-association. It is known as C.I.O. or A.F. of L. The nurses are giving them an activity which they feel needs to be done. It is just the same as—it is an admission either of ineffective organization or of unwillingness on the part of the professional organization to act to do the job the nurses want done.

MISS BOGARDUS: I don't agree that there is unwillingness to do it, Mr. Norby, by a professional organization.

MR. NORBY: I said "or unwillingness."

MISS BOGARDUS: Or lack of understanding. Possibly there is a lack of understanding of its importance. Can we have allegiance to two groups, our professional organization and the union, too?

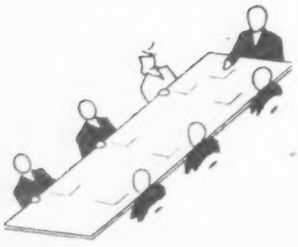
There is a great difference of opinion on that question. I am just throwing it out as a question which is frequently asked. Certainly we want to do all we can in the professional organizations to promote better employment practices.

MR. NORBY: My feeling is that it is not necessary and that you are dividing allegiance. Up to now the nurses' association has been an academic organization to some extent. What apparently is needed is an active program. There needs to be change in the personnel policies of the hospitals.

I am somewhat embarrassed, as a member of the public, that we pay a secretary just out of school more than Dr. DeBusk can start a graduate nurse on his patients' floors. But that is not the responsibility of the individual hospital. The whole responsibility cannot be loaded onto the hospital. It is the education of the public that is needed. These things all take time, and they are being worked out. I want to do things from a professional approach, rather than a labor approach.

MISS BOGARDUS: We would be quite concerned if the profession lost sight of our ideals, or our educational standards, which we have built up in nursing. Those things have got to go along together with employment practices.

MR. NORBY: The union is not in a position to take leadership in professional matters.



MRS. BELKNAP: But the nurses do belong to professional organizations. They are not set apart because they belong to the union. They still are a part. They are interested in all good work. The American Nurses' Association has done about all the good that there is to be done in the educational field, and in standardization. But in spite of all that has been done, nurses are going down the economic ladder. That is the thing. Although we are turning to new organizations to improve our conditions, we are still very much a part of the professional association.

MISS BOGARDUS: The hospital and nursing groups are responsible for serving the public, and one of the first things to think about in this connection is the educational standard in the school of nursing and service standards. Salary standards go along with these, for they are all tied together. I should like to ask Dr. DeBusk, as a hospital administrator, what he thinks is our greatest shortcoming as a professional group? Why aren't we getting enough nurses for general duty? Why are we not getting enough students?

MR. CUNNINGHAM: Over the country, to bring some recent figures into the discussion, there were a few weeks ago about 15,000 students signed up for fall classes, and there were places for 25,000 more.

DR. DEBUSK: Probably the greater part of this problem is a hangover from using the student nurse for cheap labor, although, fortunately, this is diminishing. If Mr. Cunningham's figures were broken down, you will find that schools which have exceptionally high educational standards are the schools which are getting their share of incoming students. Again, I think the solution lies in informing the public what nursing education is, or should be, plus the fact that it is a job when you get there.

I think that another shortcoming of nursing is the fact that in so many hospitals the nurse's time is divided between a certain per cent doing nursing duty and a certain per cent doing secretarial duties, or housekeeping duties, just drudgery that any person with a high school education could do just as well. The medical profession has got to understand that there is value in education. Nursing is not all arranging flowers and giving baths, as a few doctors still think.

You may find eventually that girls with a real nursing education will go out into the world and be head nurses, supervisors, instructors, or what have you, and they will probably be paid a very good wage. You will find some other people who have not had training equivalent to what our nurses have had who make the beds; and then you may find a third class that has had a little training in such things as arranging flowers and other things. You do not have to pay a little girl in her third year of high school what you pay a nurse.

MR. CUNNINGHAM: Isn't that fairly common already?

MISS BOGARDUS: Yes, but the fact that Dr. DeBusk happens to be aware of this situation does not mean it is general.

MR. NORBY: I think the home nursing programs tear down the public understanding of what a nurse is supposed to do. Patients look at hospital volunteers and say, "This is the nursing profession."

MRS. BELKNAP: Nurses' hours of work, low pay and insecurity are still a great problem.

DR. DEBUSK: I don't mean you can just talk about it and rest.

MRS. BELKNAP: In state hospitals and public health departments, you often get into politics. Political interference in the nursing field is a problem. What is being done about it by the professional organization?

MR. CUNNINGHAM: Somebody has to get into politics.

MRS. BELKNAP: Somebody has to take care of these nurses.

DR. DEBUSK: I don't deny that.

MR. CUNNINGHAM: I would like to go back to something else. Dr. DeBusk, you spoke of these possible three different levels of nursing. Already in many of our institutions we have two. You mentioned the highly trained nurse, who would have sort of administrative duties, whereas the lesser trained woman would be an assistant and rub backs and make beds. Isn't there still a place for the highly trained professional nurse at the patient's bedside?

MISS BOGARDUS: Absolutely.

DR. DEBUSK: Why, sure there is.

MR. CUNNINGHAM: That gets me back to something else. Isn't that part of the whole problem of salaries? Shouldn't there be a salary system that is different from the one we have now qualitatively as well as quantitatively? Can't we pay nurses more for nursing better rather than just living longer?

DR. DEBUSK: Yes. But when you have got a shortage of nurses you replace your nurses with people who automatically fall into the slot of having no hopes but carrying a bedpan.

If I have $1000 to pay for nursing and I have two people who are qualified graduate nurses, I will divide it $500 and $500. Now, if one person is qualified, exceptionally well educated, and one person does not have those qualifications, I will divide it $750 and $250.

MRS. BELKNAP: That is right.

MR. CUNNINGHAM: Is that kind of division an objective of the collective bargaining groups?

MRS. BELKNAP: They don't have enough professional people so we can divide them.

DR. DEBUSK: There is another thing I think these ladies here will agree with me about, and that is this: If the nurse is properly trained, educated and qualified, you would attract more and better people into nursing by subdividing it than you have today, because how many girls in a small town would go out and look for work at the hospital when they see the girls bringing bedpans around? She is not interested. Isn't that right?

MRS. BELKNAP: We ask the professional nurse to have so much education, yet we may only pay her $115 or $150 a month, even today. When this came up once in our legislature, there was a man there who owned horses. He was amazed when he found that nurses were getting $150 a month. He said, "I wouldn't pay one of my men less than $200 to take care of my horses. They are worth more to me than that." Do you see what I mean? I mean those are the things the nurses began to wake up and see.

That is education. And there are other things nurses want to know about that we are teaching them through unions—the Wagner-Murray-Dingell Bill, for example, and the O.P.A., and other current problems of interest to everyone.

MISS BOGARDUS: She certainly can be informed through the *American Journal of Nursing,* through the activities of alumnae, district and state groups. But I think we find in a good many instances that they just are uninformed about what these groups are doing.

MRS. BELKNAP: Miss Bogardus, not uninformed. You read an article about what the American Nurses' Association thinks about it. They should also be able to have a free discussion about it, both for and against.

DR. DEBUSK: There is not anything to prevent any individual nurse, or any one else, going out and seeking information. One of the activities of your organization, I take it is to—

MRS. BELKNAP: To bring these things to them, to help them with this work.

MISS BOGARDUS: If we are very ambitious shouldn't we get information on all these questions as they arise?

DR. DEBUSK: Yes.

MR. NORBY: People simply don't do that in our complex society. We do not have time to go out and find out for ourselves. But this is another activity

the professional groups can deal with. I am not sure either that the apparent success the unions are meeting with in negotiating wage contracts and personnel policies is entirely because of their efforts.

We are in a rising market, so to speak, in this type of activity. Hospital superintendents are just as anxious to get their salaries raised as the scrub ladies and the nurses are. Hospital boards are aware of the need for increasing salaries, and the public is becoming aware of increasing prices in hospital care.

I think progress is much more rapid than we had any right to expect. We are going awfully fast. I remember when hospitals hired nurses at $40 a month. Now, the minimum is $150 a month in many hospitals.

MISS BOGARDUS: It would be interesting, Dr. DeBusk, to know what has been the average increased pay to nurses in hospitals in the Chicago area. I am thinking about staff nursing particularly. In my own hospital, it has gone up a great deal in the past few years, and it probably has in yours.

DR. DEBUSK: At least 40 per cent.

MISS BOGARDUS: Yes.

DR. DEBUSK: You remember in the late 20's and early 30's nurses were coming around asking for jobs practically for their streetcar fares and board and lodging, isn't that right?

MR. NORBY: Yes, and hospital superintendents were not paid much more.

DR. DEBUSK: That is right.

MR. CUNNINGHAM: Is that going to happen again?

DR. DEBUSK: I hope not!

MISS BOGARDUS: I hope not, too.

MR. CUNNINGHAM: In the meantime, we are all in agreement the trend should be upward.

DR. DEBUSK: That is right.

MR. CUNNINGHAM: Probably the nurses still suffer from the fact that years ago all hospital people were working for just a halo—no money at all.

MRS. BELKNAP: They still have that halo. They cannot pay a nurse for what she does. There is not enough money in the world to pay for attending a man when his body and soul are tortured and he wants to live another day; you cannot pay her enough to do that. But you can pay her enough so that she has the strength and courage to hold up the light!

MISS BOGARDUS: About a year after V-J Day, I wonder if we are not looking at this quite differently because of the whole general situation than we were just before the war, for instance? Everybody is restless. There were all these nurses in service last August. We thought the situation would improve in the hospitals perhaps by October, or January, or maybe in March or June. Well, the nurses have come out of service, but they have not settled down yet. I think people who are responsible for nursing service are terribly disturbed that we are not giving a better quality of nursing service.

MR. CUNNINGHAM: Are we going to?

MISS BOGARDUS: Of course, we are going to. It won't be the same pattern it was before, though. It will be the kind of pattern that Dr. DeBusk described. I am sure Mrs. Belknap will agree with me.

MRS. BELKNAP: In time.

MISS BOGARDUS: They will give better care to patients, and they are going to have time to do it, because the nonprofessional worker is going to be employed for many tasks now taking the time of the graduate nurse.

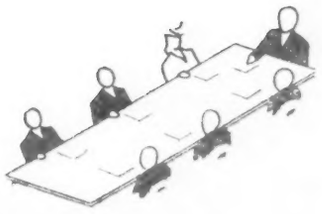
MR. CUNNINGHAM: Will this attract the nurse who is now out of nursing back into nursing?

MR. NORBY: I think it will attract more students. Not many girls have ambitions to go to college and follow a profession the rest of their lives. They are looking for something more interesting. But many girls probably feel that nursing is a good way to earn a living until that time comes. One of the big assets in the home is some understanding of nursing. If we could review standards of nursing education and not require quite as much intensive training, I think we would get more girls to select that type of activity. Then maybe a large number of these girls would be interested in professional nursing and would take additional training and make a career of it. In the end you would have an ample number of professional nurses.

MR. CUNNINGHAM: Can a nurses' union make its contribution by setting up the problem and bringing to bear efforts to achieve better personnel practices, a contribution that is a benefit to the profession?

MISS BOGARDUS: I would not say it does not bring out the problem, but I fear from what you said you have an impression that this has not been brought to the hospital administrator's attention before. We would be very happy if they would listen to us as a professional group in the same way that they have to listen to the organized nonprofessional groups.

MR. CUNNINGHAM: Mrs. Belknap, does the fact that possibly a greater part of the formal nurses' association officers are women in supervisory or administrative positions whose occupational interest is the interest of the management rather than the interest of the employe enter into your picture at all? Do you feel that in the representation of your nurses' association you have management's interests represented as opposed to employes?



MRS. BELKNAP: Well—

MR. CUNNINGHAM: Is that a problem?

MRS. BELKNAP: It is the heart of the problem, of course.

MISS BOGARDUS: In the nursing organizations, management is the group which has been trying to get higher salaries for all nurses, especially staff nurses, as Mrs. Belknap knows.

MRS. BELKNAP: We are not finding fault. We know that you have tried to do many things. Ten years ago your organization was aware of the need for better personnel practices, but in this field little has been accomplished. Perhaps because of its very nature the professional organization cannot accomplish much in this field. That is why nurses are turning to unions.

DR. DEBUSK: We are trying to straighten Mr. Cunningham out.

MR. CUNNINGHAM: Let me ask another question. Do you feel that the union has contributed anything toward making these efforts more effective? I don't know. Mrs. Belknap cites a number of instances where conditions have improved.

MISS BOGARDUS: I think in many instances they have.

MR. CUNNINGHAM: There are some instances where the nurses have negotiated contracts and raised wages.

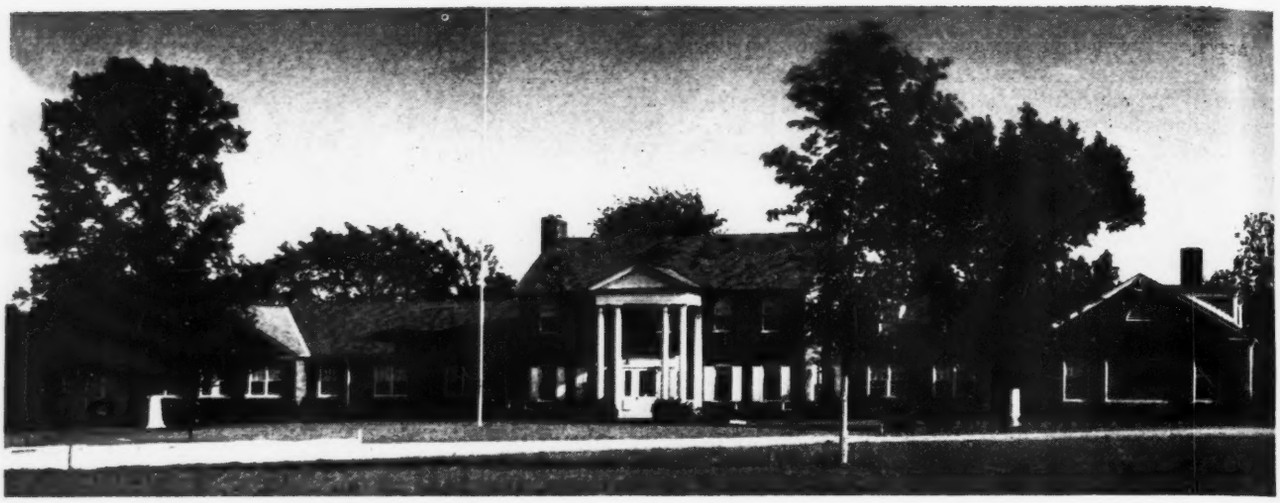
MISS BOGARDUS: Yes.

DR. DEBUSK: One trouble is that most of the leaders are, like Miss Bogardus, people whose hospitals do not particularly need all this pressure to be brought to bear. We have many meetings on this subject but not always of the people who really do need it.

MR. CUNNINGHAM: Who is going now to bring it to the attention of the others?

MR. NORBY: I think every hospital administrator would like nothing better than to provide all the benefits that are requested. But there are pressures that he cannot overcome. You all talked about the need for public education. You have to have a balanced operation. There have to be changes in the hospital nursing and personnel situation. But these cannot happen over night. It has to be evolution, rather than revolution. We cannot quarrel with the objective. It will be won. Whether it comes fast enough for all of us will depend upon how well we all work together.

MR. CUNNINGHAM: There is a welcome happy note on which to close this discussion.



Exterior of Medina Community Hospital, Medina, Ohio.

Two Years of Capacity Operation

proves that Medina needed its hospital

ABRAM GARFIELD
Garfield, Harris, Robinson and Schafer
Registered Architects, Cleveland

THE village of Medina, Ohio, county seat and general center of Medina County, had been in need of hospital facilities for some time. The citizens were well aware of this and shortly before Pearl Harbor had voted on a bond issue to provide for a city hospital. This bond issue was defeated by a narrow margin.

About that time several new industries moved into the town, one of them a highly hazardous foundry operation. The crying demand for hospital service became more urgent than ever and a citizens' committee was formed to promote an association owned hospital to be operated "not for profit."

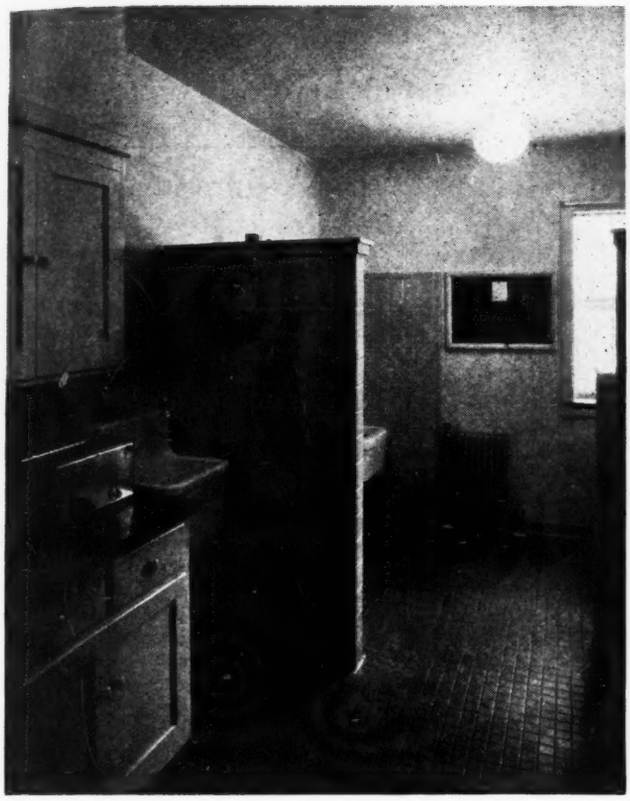
Although the city is small, it then had about 4500 people, in a not too populous county, the citizens of the city and county raised approximately $140,000 and the balance of the funds, some $130,000, was provided through a grant from the Federal Works Agency.

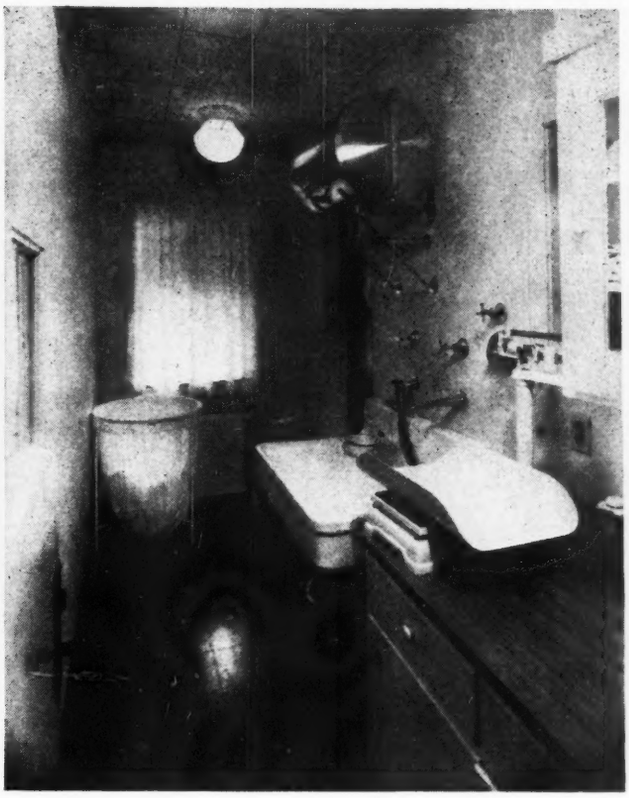
A handsome and practically new, well built and semifireproof house situated on 10 acres of beautiful rolling ground, one mile east of the city limits, was fortunately put on the market at that time. This was purchased by the hospital association and made an admirable nucleus for the new project as did its poultry house, which served as the hospital boiler plant.

Construction was started in November 1943 and the building was opened for patients in October 1944. The hospital has operated practically at capacity since the opening day.

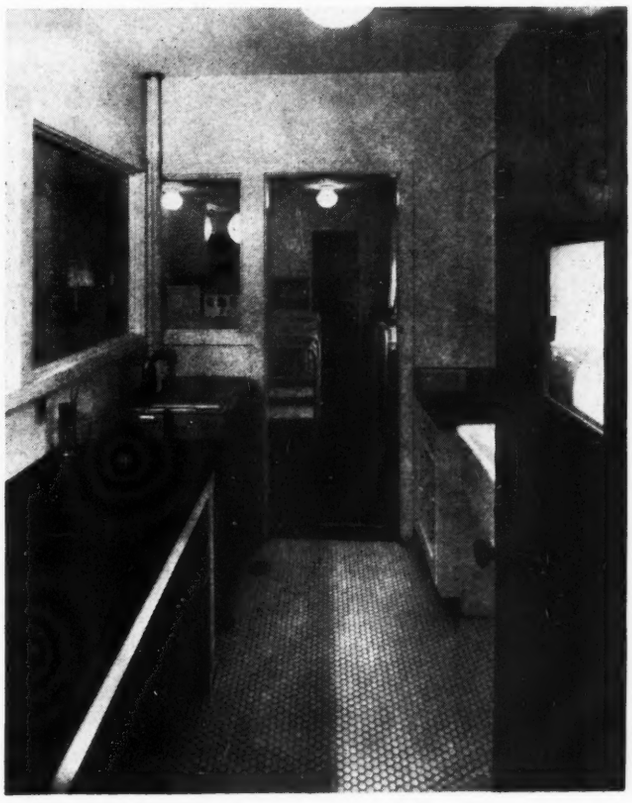
The architects were fortunate in having an extremely competent, sympathetic and industrious board and building committee to work with during the formative period, as well as several able and helpful local physicians.

Head nurses' station in the general wing of the hospital.





Above, left: One of the utility rooms. Clean and dirty sections are divided by ceramic tile wall. Floor and wainscot are also of ceramic tile. Above, right: Babies' bath is located adjacent to the nursery, which has a capacity of 14 bassinets. Below: On the other side is the milk formula room.



OUTLINE OF CONSTRUCTION DETAILS

GENERAL DATA:

New 34 bed general hospital built in 1944 around a nucleus of a brick veneer residence which, in itself, provides administrative quarters, living quarters for 12 nurses and space for 9 hospital beds, together with kitchen and staff dining room. Hospital serves a city of 5000 and an outlying community of 10,000. Bed count does not include any labor room beds (2 if necessary) and but 1 bed in the private room. Bassinet capacity is 14.

CONSTRUCTION:

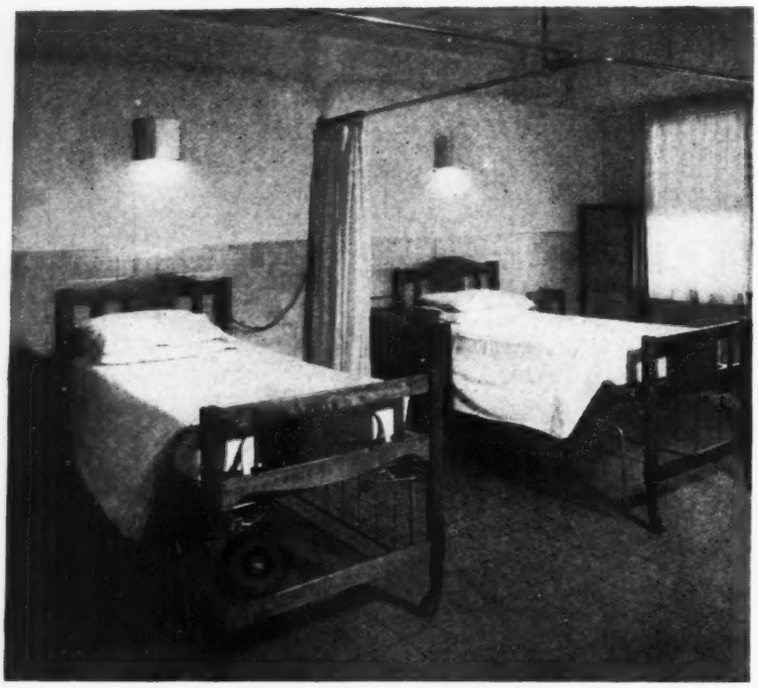
Existing residence, brick veneer with fireproof first floor slab. New construction (3 wings), brick exterior, backed up with masonry block. Floor, concrete joist with hollow tile filler. Interior partition, masonry block. First floor ceiling, rock lath and plaster on wood ceiling joists. Roof, slate on wood rafters. All sash, double hung wood. Interior doors, flush panel. Stairs, steel in new construction and wood in the original house.

HEATING:

Low pressure steam through tile conduit from isolated heating and incinerator plant, 80 feet removed from hospital proper. Heating plant building was originally the poultry house connected with the nucleus residence. Sterilizers are electric. All hot water is softened. Heating plant houses "destructor" type of incinerator.

LIGHTING:

Surface mounted throughout except for night lights in rooms and corridors, which



CONSTRUCTION DETAILS

are recessed. Surface mounted up-down lights at all bed locations. Germicidal lamps in nursery.

PLUMBING:

Because of the hospital's location 1 mile beyond city limits it was necessary to provide a complete sewage disposal plant with primary settling tank, dosing chamber and concrete filter beds equipped with rotary distributors.

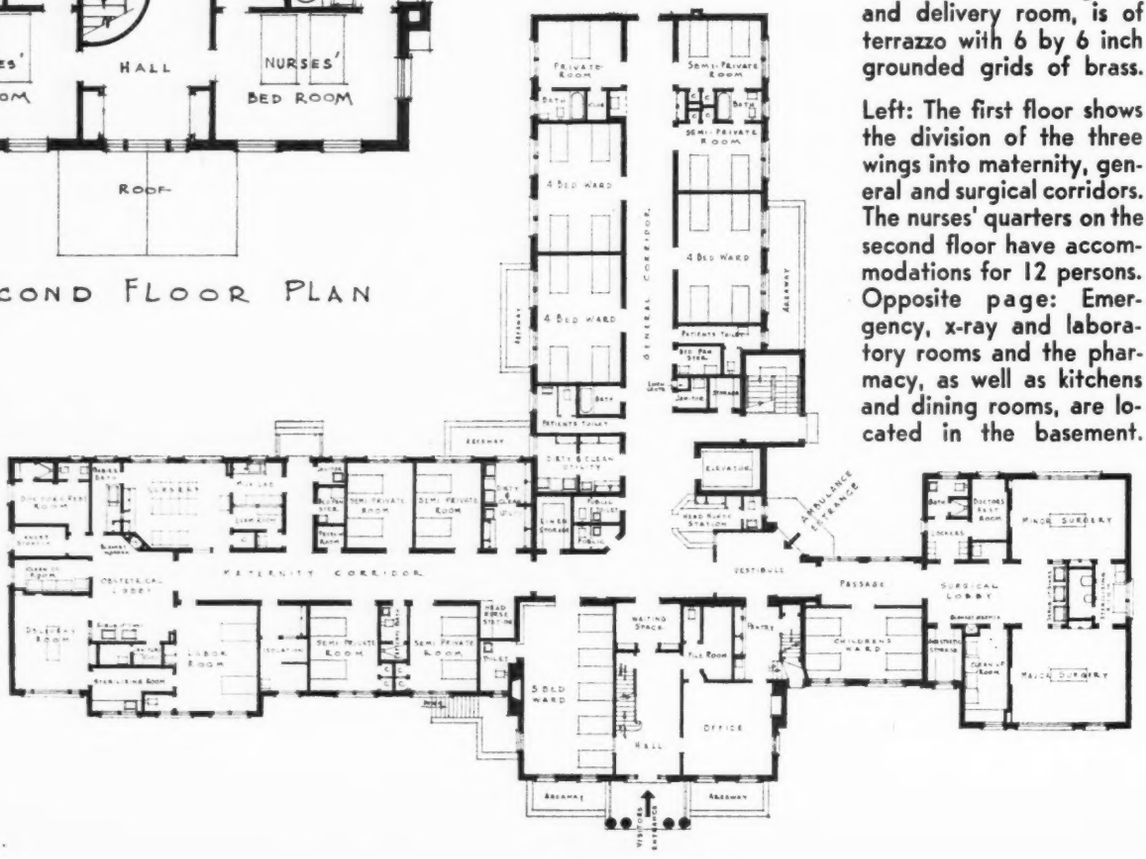
VENTILATING:

All the usual special outside spaces and regular inside spaces are mechanically ventilated. Nursery has a separate system. Delivery and labor, nursery and major and minor surgery are ventilated at present with all necessary duct work and machinery foundation in place for future air conditioning. In these rooms connections are now provided for cabinet units.

WALLS:

Plaster in all patients' rooms and corridors. Ceramic tile wainscots in all surgeries, delivery room, labor room, sterilizer rooms, utility rooms, scrubup, baths and toilets, bedpan washing and sterilizing. Glazed

SECOND FLOOR PLAN



FIRST FLOOR PLAN

Above: Labor room floor, like those of the surgeries and delivery room, is of terrazzo with 6 by 6 inch grounded grids of brass.

Left: The first floor shows the division of the three wings into maternity, general and surgical corridors. The nurses' quarters on the second floor have accommodations for 12 persons. Opposite page: Emergency, x-ray and laboratory rooms and the pharmacy, as well as kitchens and dining rooms, are located in the basement.

MEDINA COMMUNITY HOSPITAL

CONSTRUCTION DETAILS

structural block in major and minor emergency, bath and cleanup and fracture room in basement. Also in staff dining room and kitchen. Painted cinder block in other basement rooms and corridors.

FLOORING:

Asphalt tile floor and base in administrative quarters, patients' rooms, corridors and kitchen (greaseproof). Tile in all rooms having tile wainscots except for surgeries, delivery and labor rooms, which are terrazzo with 6 by 6 inch grounded grids of brass strips. Wood floors and base in nurses' quarters.

CEILINGS:

Acoustical tile in administrative quarters, major and minor surgeries, delivery and labor rooms, nursery and babies' bath, major and minor emergency rooms and bath and cleanup, kitchen and staff dining rooms. All other ceilings, plaster.

CALL SYSTEM:

Lamp and annunciator.

REFRIGERATION:

Separate units.

ELEVATOR:

Automatic with "inching" buttons, hinged doors, speed, 50 feet per minute. No dumbwaiters.

KITCHEN:

Full electric kitchen; completely served trays transported in heated carts.

X-RAY:

Complete diagnostic and light therapeutic equipment.

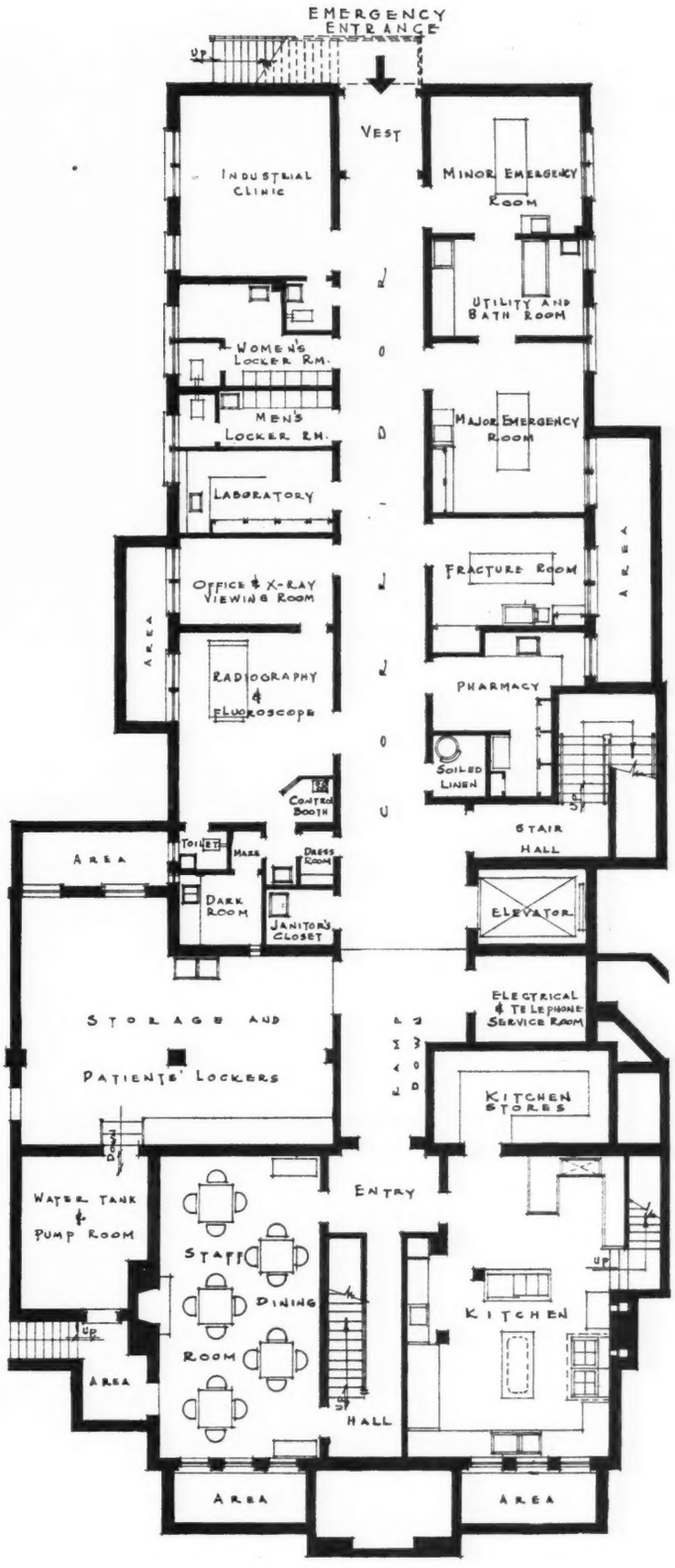
LAUNDRY:

Because of the availability and favorable rates and delivery schedules of Akron and Cleveland laundries, no on-the-site laundry operation is contemplated for the present.

COST:

Land, $5000; nucleus buildings, $20,000; new construction (new hospital wings, including sterilizers and kitchen equipment), rehabilitating and converting the nucleus buildings and building sewage disposal plant, $209,027; elevator, $4200; furnishings and equipment, $31,000. Volume, 230,000 cubic feet.

Taking the cost of the new work and deducting the portion applicable to the sewage disposal plant and adding that portion of the cost of the nucleus building that is devoted to hospital purposes only, and not to nurses' home, the unit cost figure is 90.5 cents per cubic foot for the hospital building proper, exclusive of land and architects' fee, and $5950 per bed.



•BASEMENT FLOOR PLAN•

The Spoken Word Tells Our Story

CARL I. FLATH
Administrator
Charlotte Memorial Hospital, Charlotte, N. C.

WHEN we examine again our diagrammatic formula for hospital public relations the spoken word comes into play a surprising number of times, that is, if full advantage is to be taken of all public relations mediums in the process of reaching the hospital's nine publics.

To begin with, there is the personal contact (between employes or officers and the several publics) in day to day service or working relationships; next there is the intimate administrative contact with the board and, finally, the more formal administrative contact with the hospital's larger publics through meetings, public appearances and the radio. Yes, the spoken word must be given a place of greater importance than that usually accorded it in a total plan of publicity.

You don't like the word "publicity" in relation to hospitals! Why not? It's really a very good word. It simply means making information public. What's wrong with that?

Using the Spoken Word—Individual to Individual: In all our professional, social and casual relationships, the spoken word is in perpetual use. Applied with judgment and understanding, it can be a highly important factor in shaping public impressions and opinion of hospital work. While hospitals have developed skill and technic in respect to many relationships with the public, most of us have, generally speaking, left this important form of interpretation, the spoken word, to chance.

It begins with the voice of the telephone operator and continues through every contact that any worker within the hospital might have with another human being. It never ends. Hospital employes cannot be isolated from opportunities to defend or explain the hospital or some phase of its activities not only in their daily work but to their families or acquaintances. How well are they equipped fully to exploit these advantages?

To be true, everyone cannot be a brilliant conversationalist, but the first principles of interpretation by the spoken word can be recognized, learned and used by anyone. We can be *friendly* and *direct;* we can be *courteous;* we can avoid talking either down or up to a questioner; we can be *accurate* in our statements or frankly admit that we don't know. We can, at least, leave an impression in the minds of listeners that we are honest, competent, sincere people and are trying to do the best job we know how to do for those in need of help. Just the creation of such confidence is a long step forward in public relations.

There is little opportunity to prepare for this sort of casual interpretation, individual to individual. But the important thing is to realize its value and to be sure that everyone associated with the hospital in any capacity has been armed with adequate information—and the right information—to ensure the hospital's being defended or interpreted in the most favorable manner under all circumstances.

We hear and read a lot these days about the "employe manual or handbook" as something indispensable in any good personnel relations program. The obvious reason is that it is the most effective and permanent vehicle for interpreting the hospital, its personnel policies and what it stands for to employes. In public relations it is no less indispensable and in its preparation a public relations slant should be incorporated. Good personnel relations is the real beginning of good public relations. And, in the process of formulation, all personnel policies should be translated in terms of their effect upon public relations.

Using Spoken Word to Board and Committees: The most intimate public relations audience consists of our partners, the board of trustees and its committees. Theirs is the policy forming responsibility of the partnership and ours, the executive. And our concern as interpreters to these partners is to keep them keenly interested and well equipped to do their share of the work. Well informed and actively interested boards can be tremendously effective in both the formal and the informal type of public education through their individual and varied daily contacts. Conversely, an uninformed board member is constantly on the defensive and is the poorest kind of public emissary.

Our best chance to bring about real understanding to the board comes at its regular meeting.

In selecting and preparing material for a report to the board on current work of the hospital we should make use of the same news sense which comes into play in the preparation of other types of publicity. Reports should be specific, timely, interesting—but brief. As a rule there will be sufficient time for thoughtful preparation of this type of interpretation and, while it is more formal than casual conversation, the opportunity to make a speech should be avoided.

On the other hand, the report should contain more than just a review of administrative and financial detail. We should search for facts that the board should know and will be interested in knowing, then the facts should be presented vividly enough to be remembered and to be repeated to the business, professional or social acquaintances of the board members.

In addition to the administrative report, variety can be introduced by bringing into the meeting of the board different members of the staff, medical and lay, to give firsthand ex-

periences and reports. This is especially important if there has been occasion for board and staff members to work together on any particular problem or project.

Using Spoken Word in Public Meetings: What most hospital people need is not more invitations to speak at public meetings, but better use of the meetings.

When the spoken word is carried to the public through meetings, of either our own or outside groups, we are simply moving from a small room to a larger room, from an intimate circle to one less familiar, from an informal to a formal atmosphere. Nonetheless, we should carry with us the same simple friendly approach, the same careful selection of material, the same restraint and respect for the point of view of our audience as would be present in conversational interpretation with an individual.

It is not every hospital administrator who is capable of speaking in public; and if the administrator is convinced that he can do nothing about this situation, either by practice or by study, some member or members of the board should be assigned the responsibility of making public appearances. But no opportunity should be lost to take the hospital story before every type of public audience—whether it is a women's sewing circle at the First Baptist Church, a school group or the state medical society—simply because the administrator himself is reluctant to talk in public. (Some observations on speaking in public conclude this article.)

There are many good ways of using the spoken word in public meetings in addition to a formal talk or speech. Among these are the dialog, a quiz or a panel discussion and the dramatic sketch or play. These latter are really nothing more than extensions of conversation. Write down questions and answers: you have a dialog. Add a few more people: you have a panel or discussion group. Introduce action and a plot and you have a play. Most hospitals could use these devices more frequently. When properly planned and thoughtfully written, they can be tremendously effective.

Using Spoken Word on Radio: When a hospital goes on the air it carries the spoken word out to its largest audience, the general public. But, when plans are made to go on the air, it is to be remembered that a radio audience is the most casual, miscellaneous and merciless of all of the publics to which we have to tell our story. It owes us nothing and can walk out by thousands simply by twisting a dial. It is, for the most part, more interested in being entertained than informed or persuaded. However, there are elements of the radio audience that will stay with us provided our material is timely and is skillfully and clearly presented. In general, most people are interested in matters having to do with health. For example, mothers are anxious to listen to a meaningful program having to do with child welfare.

Further to emphasize the indifference of radio audiences, this is what David Sarnoff, president and general manager of the National Broadcasting Company, has to say: "What the public demands of radio is entertainment, and educators who wish to use it and do not recognize this fact are simply using blank cartridges. When educators use the radio, they must become members of the show business."

Thus, hospitals should realize, if their public relations program gets into the use of radio, that they are always competing with expensive talent and showmen of real ability. For that reason, unrehearsed speeches presented in technical terms and delivered without warmth or ease of manner are not likely to be more effective than shouting down a rain barrel.

In selecting material for presentation over the air, news sense must again come into play. Material should be selected that will tie into what people are thinking about and talking about at the moment (polio in an epidemic area, for example). I think it is good advice to say that in the selection of material and its method of presentation, we should always picture ourselves in the place of the listener.

Furthermore, anyone who is not a regular and almost inveterate radio fan should not attempt to plan radio presentations. Even this amateur expert, after having decided what useful information he might be able to give to the radio audience and, in relation to it, what part of the work of the hospital is sufficiently interesting to hold attention, should consult with his local station manager before proceeding too far.

Actually, when we think about it, there is quite a variety of radio presentations that hospitals should be able to use effectively. These will range from the simple spot announcements, inserted into or between sustaining programs, to town meetings, quiz programs or even full length plays. But whatever we plan to do on the air must be good—it must not be "corn" (in spite of the fact that a claim is made to the effect that the average radio show is slanted to a 13 year old intellect).

So You're Going to Make a Speech! (Hints gleaned from some experts): If you're weak in the knees at the thought, get to work on your speech, start digging up material. They say nervousness charges your batteries. Find out what you're afraid of and you'll discover it's nothing much; stop worrying; getting ready for a speech is painful, giving it is fun. Find out about your audience. How large is it, is it school kids or college professors, will there be other speakers and what are they going to talk about? If you are to follow a humorist don't try to be funny.

If your name is hard to pronounce (like mine) make sure the chairman gets it right, ahead of time. Men will usually dress appropriately and conservatively; what else can a man do? But a woman! If she's inexperienced she'll probably give more thought to what she is to wear and how her hair is to be done than she will to the preparation of her speech. What woman should do is to

avoid overdressing, avoid flowers and other eye-catching distractions, such as flashy bracelets; and if she must wear a hat, avoid the greenhouse, vegetable garden or birdhouse variety. For a woman, good grooming for public appearance demands a tailored, you're-going-to-stay-together-and-on-the-ground sort of outfit. (Yes, I know my neck is out.)

Put the speech on paper; write it out fully; then put it into outline form and, finally, into notes on small cards. Don't read the speech if you can avoid it; don't mix up your note cards or get ahead of them either; memorize notes but not the speech; don't leave your notes at home. Direct the preparation and presentation at one composite person, just like you. If you do you will use simple language — maybe a little slang; you won't be hostile; you will talk down to earth; you will be natural.

Decide what you want to say, what response you want from the audience; concentrate on that and make it purposeful. You can't tell everything in ten or twenty minutes; decide what you can cover and concentrate, don't wander. Build remarks around a main issue tied into a schoolbook formula: opening, body, conclusion. Stay on this track and number your points; your listeners can't ask you to repeat. Don't be afraid of looking like a novice; most of your listeners could not do as well and they know it.

"Open strong, wake up the audience, kindle a fire," says one author. Make a dramatic, startling statement related to the main theme. Show something related to the main theme —a letter, a chart, a picture. Use examples—small talk about some current happening known to your listeners won't hurt. Avoid big words that are unfamiliar to the listeners. Most speeches are designed to get something done; the conclusion should make this clear. Ask for the action you want, show them how, then stop, don't just run down. Don't run overtime.

Irvin S. Cobb said, "No speech is bad if it's short enough." The Gettysburg Address was only two minutes. If you need to fill out time, have a discussion period. Above all, speak up, make sure the fellow in the back seat can hear you.

COLOR and Psychotherapy

FABER BIRREN
New York City

COLOR for the sake of color is hardly enough to answer the needs of hospitals. Although it admittedly is better than drabness or the excessive "sterility" of white, it requires some conservatism and purpose in its use.

The very nature of hospital service would suggest that every application of color be technically right, that matters of appearance be supplemented, if not dominated, by a vital regard for visual and physical comfort above mere esthetic pleasure.

While almost any hue may be considered attractive, not all colors or tones of color have equal utility and value. Choice and discrimination should be founded on reason and function, and a set of hospital specifications can be written that adhere to good scientific practice.

It should be understood that visual fatigue is at a minimum when all major areas and surfaces in the field of view are relatively uniform in brightness. This overcomes adverse pupillary adjustments which lead to distress. At the same time, excessive brilliance should be avoided lest glare exist and the eyes of patients and personnel be overstimulated.

Ideal comfort will be found in colors that range in brightness from 60 per cent reflectance (on walls) to 25 per cent reflectance (on floors). Brightnesses above or below these limits, particularly if they are found in the same environment, will cause trouble.

If color is pleasing to the eye and emotions, it may also be distracting. Yet even distractions hold advantage under certain hospital conditions. The important factor to bear in mind is that the application must be appropriate to the situation. In other words, the color effect should be functional, directly related to the special seeing requirements of each department and not treated as a quality apart. Even too much cheerfulness gets on the nerves at times.

With such an attitude in mind, intelligent order and purpose can be put into the design of a hospital color plan, brilliant in some locations, reserved in others.

In lobbies, reception rooms, parlors and solariums variety should be introduced. These spaces normally are frequented by visitors as well as patients. Too much of any one color should be avoided. There is a psychological reason for this. All-over color effects invite definite emotional reactions which may be unfavorable as well as favorable.

To shift emphasis from any precise mood, neatly chosen color sequences will help to break up monotony and treat the eye to an interesting "change of pace." Pale ivory or peach walls, for example, may be contrasted against soft tones of green or blue in floors, draperies, upholstered furniture. Or soft green or blue on walls may be accompanied by rose tones in furnishings. Also, it is often desirable to carry out the warm effect in enclosed spaces deprived of natural light and to use the cool hues for adjoining rooms.

If as the patient or visitor walks about he is exposed alternately to warm and cool effects, severity will be avoided and any feeling of excitation or depression will be re-

lieved because of variety rather than uniformity. This is a psychological device that has universal appeal and may be used with excellent success where relatively large groups of people are involved.

In corridors and stairways, the use of color may be planned to compensate for lack of natural light. Pale yellow and peach are ideal. They not only appear "sunny" but are moderately aggressive in quality, "pick-up" the mood and provide agreeable contrast with softer and cooler tones recommended for private rooms and wards.

In accommodations devoted to patients, good color practice would suggest the following principles. First of all, wall tones should be a trifle grayish and not too bright. Such "muted" colors (with a reflectance of from 50 to 60 per cent) will be restful, free of impulsive distraction and practical in resisting soiling and abuse.

Dim Light More Restful

Ceilings may be in a lighter tint of the same hue. While it might be desirable to use soft tones of peach, rose and ivory for north exposures and soft tones of green, blue and gray for south exposures, a better principle is to try to restrict the warmer hues for convalescent patients and the cooler hues for chronic patients. Rooms may also be "conditioned" through regulation of illumination, dim levels of light being restful and brighter light more stimulating.

Three major color effects are proposed. The first of these is a soft blue-green, the complement of human complexion. This color creates a cool and relaxing environment and, by contrast, tends to give a pinkish blush to patient and visitor.

The second scheme is comprised of a soft peach, the tint of human complexion itself. In relatively small interiors (without much sunlight) it tends to increase room dimensions. Reflections from it cast a pleasant glow that flatters human appearance.

The third scheme is to use a soft pearl gray, relieved by delicate multicolors in furniture, flooring and draperies. Gray is a beautiful and functional color when it is agreeably harmonized. It is, of course, a perfect foil for almost all other hues.

In operating rooms and surgical departments, blue-green is also suitable. Large expanses of white, regardless of their apparent cleanliness, are trying on vision. They constrict the pupil of the eye and make seeing difficult.

Nurses' stations may be in pale yellow or peach for a slightly aggressive effect. Utility rooms, diet kitchens, linen rooms may be white where occupancy is not too constant. Otherwise, pale green or blue-green is advised.

Where patients or staff may be exposed to relatively high temperatures, such as physical therapy, x-ray rooms and laundry, blue-green is ideal. In offices and laboratories, however, the color effect may be guided by room orientation—ivory for north and east exposures, gray or green for south and west.

Blue as a color should generally be avoided over large areas. It has a depressing effect on many persons and seems to trouble the eye by causing a nearsighted adjustment of the lens. However, it holds universal popularity and makes an excellent choice for occasional end walls, floors, upholstery fabrics and incidental accessories.

In classrooms and conference rooms, end wall treatments may be employed. Here the device is to use a light color, such as ivory, on the side and back walls of the room for high light reflection and to paint the end wall—faced by the students—in a medium tone of green or blue. This will cut down glare, relieve the eyes and build up higher visibility for the doctor or instructor, or for any charts or demonstrations presented.

End walls in soft colors have many applications. Dark, vaulty spaces may be enlivened with an end wall in yellow. In laboratories where critical seeing tasks are performed, deeper hues on end walls will give the eyes a chance to rest and provide convenient areas for visual and emotional relaxation.

For dispensaries, light pearl gray is ideal for the waiting room, relieved by furnishings in cheerful red or blue, or a combination of both. Examining and treatment departments may be in blue-green. Dressing rooms and toilets may be in peach to reflect a healthful glow upon the flesh.

In the nurses' home, more of an interior decorator's point of view may be expressed. However, here, again, research in color preference may be relied upon to make sure that each use of color has unquestioned appeal. Rose tones hold great popularity among women and, hence, are ideal for parlors and bedrooms. In dining rooms, studies in the psychological associations existing between colors and foods have shown peach to be the most "appetizing" of all hues. It affords an appropriate and pleasing environment—and is harmoniously relieved by the use of blue in draperies and furnishings.

Finally, color can be coded for purposes of safety and identification. Such a code, developed by the Du Pont Company with my collaboration, and recognized as a national standard, should be considered. Fire protection equipment should be identified through the use of red. Any first aid devices may be similarly distinguished with green.

In mechanical departments, yellow (or a combination of yellow and black bars) is the standard to mark stumbling or falling hazards, low beams or the edges of platforms. On stairways, it is excellent practice to use a 3 inch band of high-visibility yellow immediately under the nose of the tread on top and bottom risers. Corners should be painted white to discourage littering.

Pipe Markings Advantageous

Pipes for safe materials, water and sewage may be marked with green, gray, white or black on elbows, valves and fittings. Pipes for dangerous materials, such as gas, may be marked with yellow or orange. Valuable materials may be marked with purple. Fire mains and sprinkler lines should, of course, take red. With such standards maintained, the work of the mechanical department will be facilitated and hazards will be minimized.

Painting is a sizable maintenance expenditure in all hospitals. Because of this there is every reason to make sure that color is used rightly and that every possible dividend is realized. In the main, it costs no more to apply good colors than mediocre or bad ones. Hospital management has, in the medium of color, a real opportunity to bring greater efficiency into its building, lessen fatigue, indirectly aid convalescence and increase its prestige within the community.

Health Centers Under Two Roofs

to serve the people of Cincinnati

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THE problem involved concerns the remodeling of two adjacent brick buildings, situated in downtown Cincinnati. These were a two story building about 70 years old and a four story building, 54 years old. Both were erected by the same owner, an eye specialist, the two story building having been his town house residence. In the four story building the doctor had established his office, an eye dispensary and an ophthalmological hospital consisting mainly of an operating unit and private and semiprivate rooms for patients.

The four story structure was built with the idea of connecting it to the two story house at the first and second floor levels. There are two small areas and a small unoccupied space situated to the north in the rear of the buildings. The health center is accessible at the front and by means of alleys at its eastern and northern sides.

Financed by City

The two story building, 39 by 76 feet, was purchased by the city of Cincinnati in July 1938 and has been used by the city health department as a health center on a moderate scale since that time. In order to increase municipal health center facilities and services, the four story building, which is 35 by 72 feet, was acquired by the city in October 1940. The purchase, as well as the remodeling of the buildings and the creating of health center facilities therein, was financed at intervals by the city administration, with the exception of the procurement of some important and expensive x-ray equipment which was supplied to the city by the Cincinnati Anti-Tuberculosis League.

Under the leadership of the Cincinnati Board of Health—the president of which is Dr. William Muhlberg—and its health commissioner, Dr. Carl A. Wilzbach, the project has been developed under my direction as consultant to the board on health center planning. The isometric plans reproduced here were drawn by Thomas E. Shepherd who also assisted in preparing other necessary drawings.

It was intended to publish this outline when the entire project had been completed according to original plans as described herein. However, up to this time it has not been possible to establish health center facilities above the second floor level because an elevator, a fire escape and various other items could not be obtained. Besides, in the meantime, some adjustments of the program were made mainly in order to organize, at least temporarily, a much needed clinic for well babies at the first floor level of the four story building. Yet it is planned eventually to complete the reconstruction of the health center according to original plans.

The general aims and aspirations of the plan were to create a useful health center, an adequate one from the standpoint of public health, medicine, nursing, architecture and engineering; an efficient one from the standpoint of health center management, and an economical one from the standpoint of cost of operation.

Specific objectives of planning were: (1) to arrange the health center along the lines of its future functions but within an existing pattern as determined by the buildings' massive outer and inner walls of between 12 and 22 inches in thickness; (2) to do total planning directed downward, making provisions for the future placement of details of equipment; (3) to arrange the plan by developing the smallest units first and to do so by building partitions around projected equipment, which may not be placed there until later, and also to form a variety of suitable health center rooms and traffic lines in this way; (4) to cut existing brick walls only at places where additional openings were much needed, and (5) always to bear in mind the element of flexibility that is so important to the adaptability and efficiency of future health center management.

Cheerful Atmosphere Provided

Furthermore, special consideration was given (6) to providing convenient surroundings for patient, doctor, nurse and clerk; (7) to assuring complete privacy within all medical offices and interviewing rooms by means of visual separation and soundproofing; (8) to building locked cubicles for undressing, adjoining all medical offices, and (9) to providing waiting rooms, spacious enough and planned in an economical way but to be attractively equipped. The use of pleasing wall and floor treatment (linoleum layout) and furnishing the waiting rooms with ensembles of tables, benches and chairs, and also with pictures and evergreens, help to create a cheerful, inviting atmosphere.

As already indicated, the planning included the selection and placement of medical, clerical and other equipment. In particular, it was arranged to put convenient writing desks in places adjacent to windows; to build in an incinerator chute, a linen chute and nearly all lockers and cabinets for linen, chemical and clerical supplies, books and various other items, and to insert a number of small inner wall and door windows to improve communication between adjacent medical and clerical offices

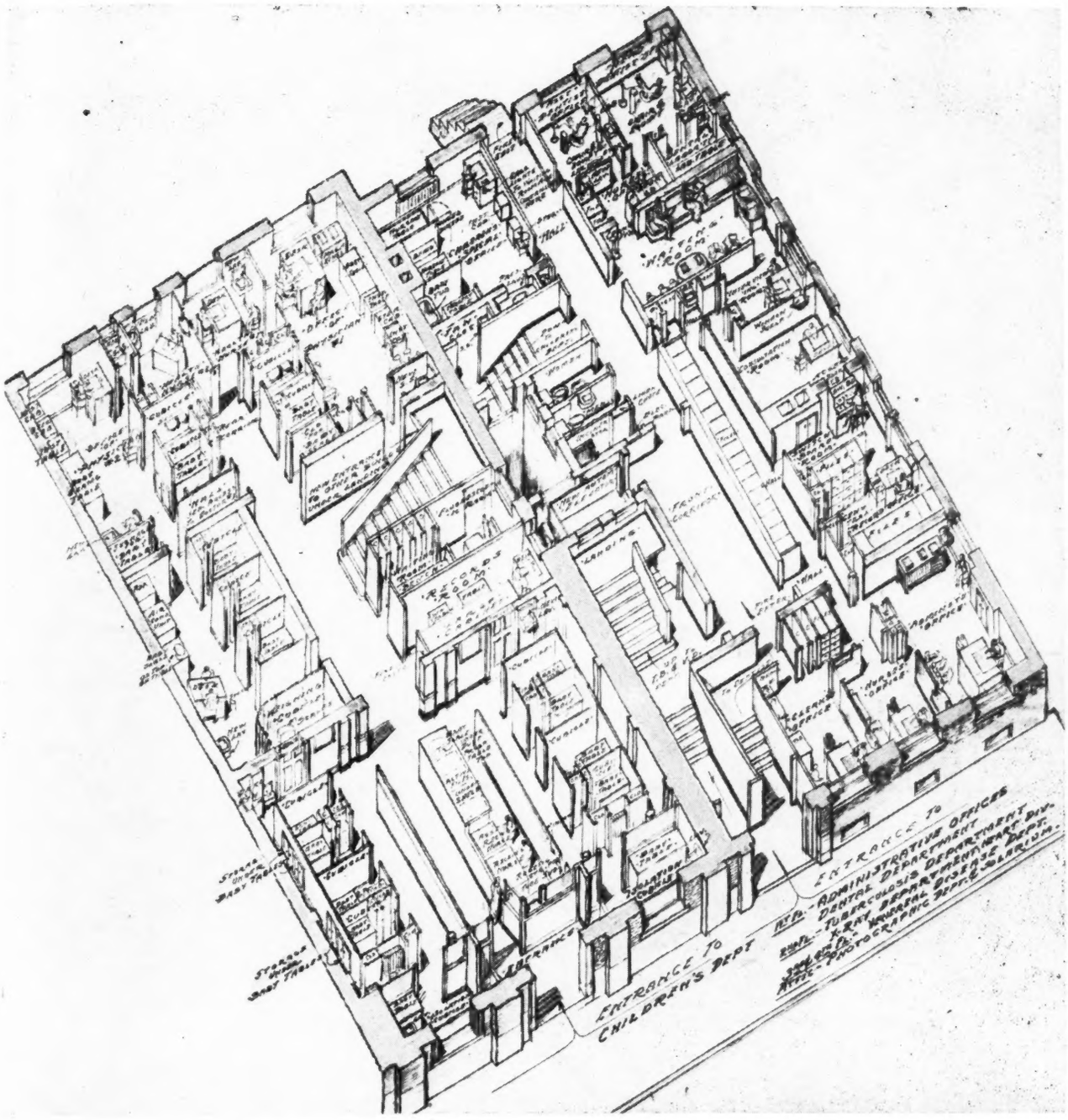


Fig. 1. Children's and dental departments, administration—first floor.

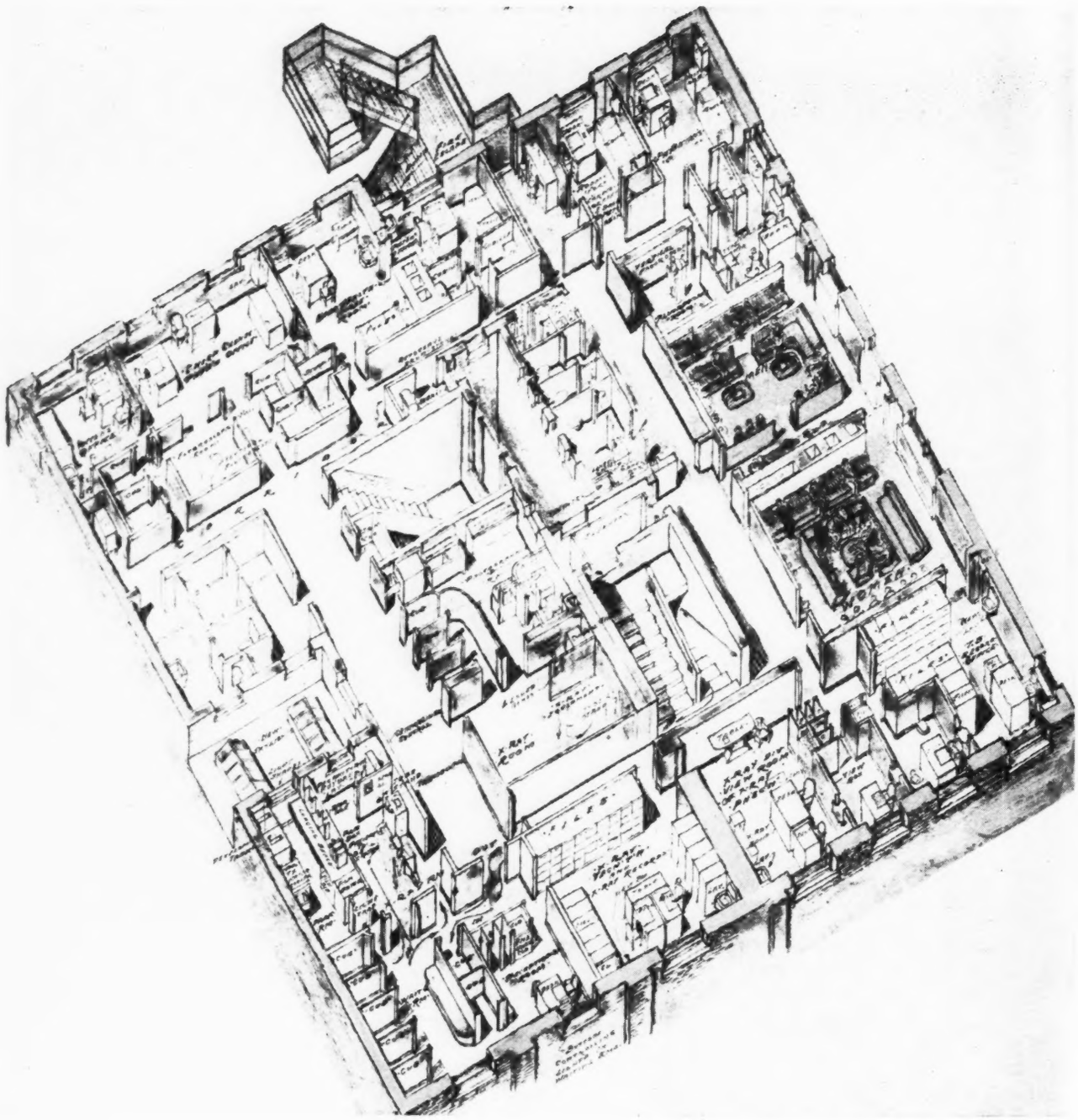
and other health center rooms, and also to increase the possibilities for occasional supervision of patients in the waiting rooms. Provisions were also made for the proper placement of bulletin boards and directional signs.

It had been planned for the future further to facilitate the circulation of patients within the health center by the installation of a signal system and to arrange the transportation of records by means of a pneumatic tube system.

The isometric drawings as reproduced here correspond to and are identified with the floors of the health center. In particular, they display the location, organization and intended function of the various divisions of the health center: a maternal and child health division, a dental clinic and general administrative offices on the first floor; a division for pulmonary tuberculosis and an x-ray department on the second floor; a division for venereal diseases on the third and fourth floors, and a children's solarium and rooms for a photographic workshop at fifth floor level (the present attic).

Provisions were made for a projected interviewing room and a consultation room at first floor level for receiving new patients not yet assigned to one of the divisions of the health center and for conducting mental hygiene clinics or premarital advice and marital consultation services. Space for a clinic for cardiac cases was selected in the northeast corner office unit on the second floor. At present, because of lack of an elevator, this clinic is held on the first floor.

Facilities belonging to the x-ray divisions were designed to accommodate placement and operation of two x-ray machines, macro-x-ray and micro-x-ray equipment, respectively, and to include adjacent offices, waiting and disrobing rooms.

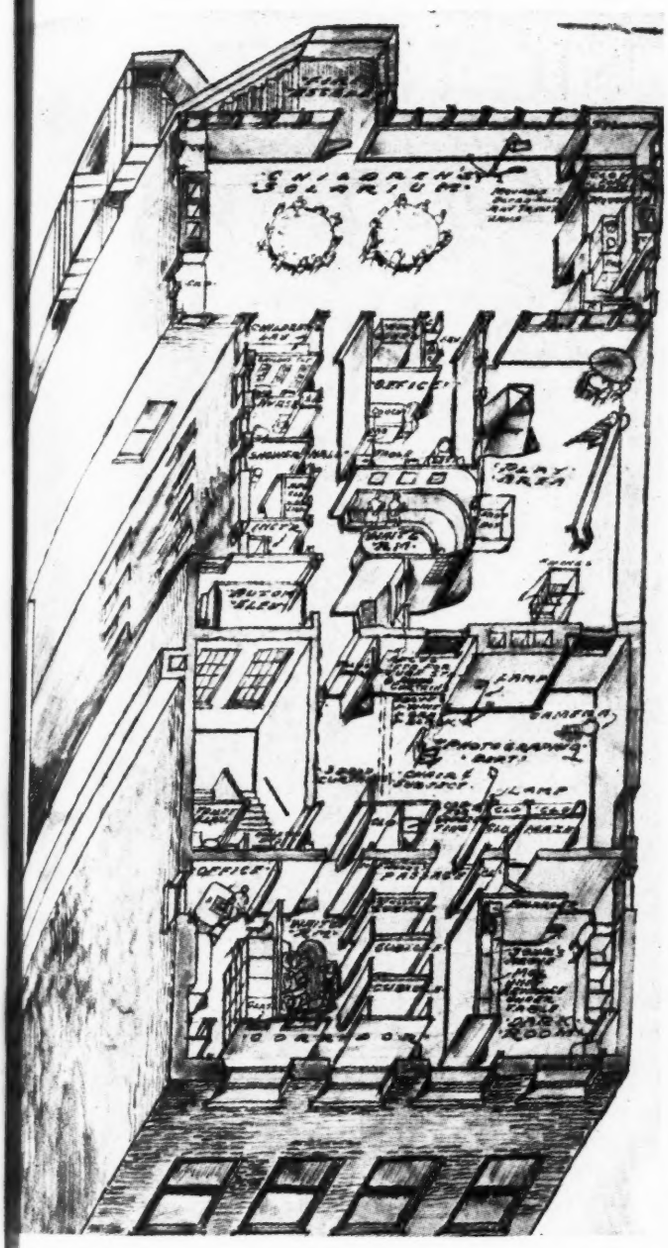


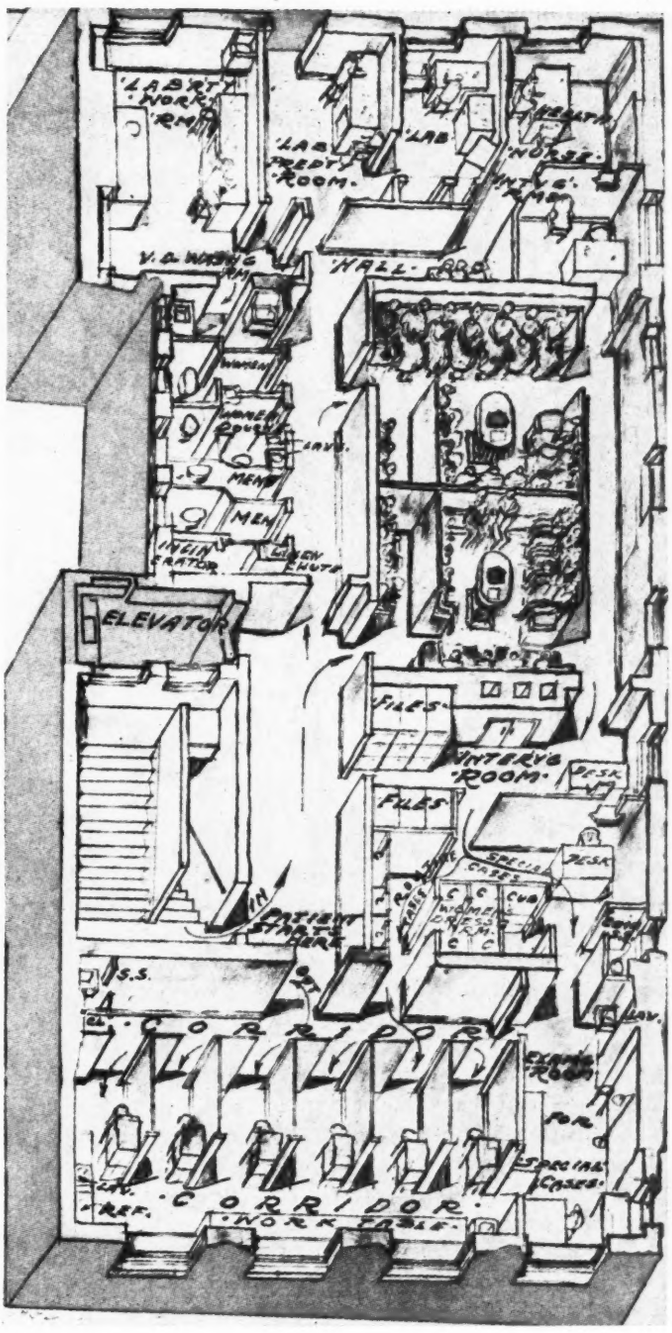
Rooms for records were provided within respective departments as was a record corridor adjacent to general administrative offices on the first floor. The four story building on its southern side has an attic that, after remodeling, may be suitable for a photographic workshop. Plans were developed accordingly. Some of the projected rooms may also be used for conducting refraction clinics. Isometric drawing No. 3 contains also provisions for the arrangement of a much needed children's solarium and a few adjacent rooms to be built on the northern part (a flat roof) of the four story building. Besides, some appropriate space situated in the middle of the eastern side of the roof was selected as a roof garden play yard for the children.

It is somewhat difficult to estimate the size of the area to be served by the health center which, as has been indicated, is situated in downtown Cincinnati. The majority of Cincinnatians who belong to the low income groups and to the indigent live in this part of the city, especially within the western downtown census tracts, the so-called "westend basin."

One has to consider the amount of service rendered by similar but smaller health establishments within the health center area, such as the work done at (1) Shoemaker Health Clinic, a charitable institution operated on behalf of a part of the Negro population; (2) a unit consisting of a clinic for venereal diseases, a dental clinic and a child health clinic, organized and directed by the board of health at the Cincinnati Union Bethel buildings, and (3) three other downtown well-baby clinics (substations) conducted under the management of the Cincinnati Babies' Milk Fund Association.

The health center may have to serve a downtown area comprising a total population of approximately 120,000, while the proportional part of the Negro population residing





Opposite page; Fig. 2, tuberculosis and x-ray departments—second floor. Above, left: Fig. 3, solarium and photographic department—fifth floor. Right: Fig. 4, V. D. department—fourth floor. Third floor not shown.

there may be equal to about 40,000 persons.

A number of people who live somewhere on the "seven hills" of Cincinnati may also come to the City Health Center and use its services and, conversely, a certain percentage of people living downtown will frequent health clinics in uptown Cincinnati. Furthermore, an indefinite number of out-of-town people, mostly indigent, are to be considered as prospective clients of the health center. This fact may be surprising at first glance and there may be an inclination to criticize the resulting expenditure out of city funds on behalf of such nonresidents. However, from the standpoint of epidemiology and also in the interest of the resident population, it is often mandatory to use the health center's facilities and services for that purpose, especially in Cincinnati, a gateway city situated at the very crossroads of considerable interstate migration.

The number of visits to the health center, affecting all divisions, was 89,009 in 1944 and 91,205 in 1945, and the total visits at the newly enlarged tuberculosis and x-ray divisions amounted to 11,955 and 15,969, respectively, in 1944, and to 13,848 (8309 white, 5539 Negro) and 15,498 (10,607 white, 4891 Negro), respectively, in 1945. There seems to be little doubt that health center work in these and in other divisions could be enlarged considerably and even doubled later on, if necessary, by adding day as well as night clinics, provided that such indispensable additional personnel as doctors, nurses, clerical and social workers was available and could be added to the staff.

It is hoped that the health center as it has been planned will be useful as a center of preventive and curative public health service, as a focus of public health education, as a place for professional training of men and women in medicine and public health and as a medium in the field of public health nursing.

MUSIC Is in Tune *With the Art of Healing*

PHILIP J. JACOBY
New York City

THE great preponderance of recent study of hospital music has been directed at discovery of specific properties, especially as they may apply to mental patients. Some of the publicized tests have been vulnerable to charges of sensationalism. Evidence has been recorded on a basis of individual case histories rather than on any general objective plan.

The cumulative effect of these reports has served to confuse rather than to inform. They have, unfortunately, created for music an aura of speculation and witchcraft.

Regardless of the many splendid results that have been attained, the evidence still remains indecisive largely because the individual backgrounds and personalities of both doctor and patient have been such important, if not entirely controlling, influences. The entire field of psychotherapy is fraught with imponderable considerations.

Although the famous German surgeon Billroth admitted he operated most brilliantly after attending a concert, and although Dr. Esther Gatewood reported that music used when a patient is coming out of anesthesia helped induce natural and undisturbed sleep, papers on the subject of music by surgeons or general medical practitioners are few indeed. It is significant that music in healing has been almost exclusively defined by the psychiatric branch of medical science. This has given the subject unwarranted esoteric connotations.

Actually, we need not cite laboratory or clinical experiments by Fere, Tarchanoff or Binet to substantiate that music possesses positive powers which exert themselves on our mental and physical well being. This is universally recognized not only by doctors but by laymen as well. To deny it would be to deny the evidences of our own personal experience.

Music in the war plant proved useful in combating fatigue and overcoming occupational boredom. It made a valuable contribution to victory in keeping the worker at his job and the materials of war moving off the assembly line. The same reasoning that employs music at work pertains with marked aptness to considerations for music in hospitals.

There is still another parallel between work music and hospital music in the history of its acceptance. The value of work music was early recognized by both industrial management and labor. It was recognized by the government. The War Production Board was one of its staunchest advocates. President Roosevelt urged that "music builds morale. It inspires our fighting men on battlefronts abroad and at training camps at home. It spurs soldiers on the production front to new goals. It refreshes all of us, young and old alike." It was only with those in the music profession that reservation was encountered in yielding support.

So, in hospital music, endorsement pours in from patients and guests who have been exposed to hospital music programs. We find that the hospital technician is all for it. It is the doctor, who should realize best of all the attributes of music, who offers what resistance there is to hospital music.

The musician and the music educator have recently discarded the prejudices they held against industrial music and the doctor is slowly placing a true evaluation on hospital music. This is a most gratifying sign and speaks well for the future of functional music.

The number of dentists who play music when drilling teeth has sharply increased lately.

The Red Cross blood bank in Brooklyn, N. Y., eliminated fainting by nervous blood donors by installing music supplied by a wired music service.

These and numerous other specific examples of benefits have pointed the way to music in the general hospital.

Music's first place belongs in the realm of morale. Webster defines morale as "mental or moral condition especially as affected by zeal, spirit and hope." What doctor or hospital authority would dispute that morale is a strong influence on if not a condition precedent to convalescence and recovery?

It has been advanced that music is fundamentally pleasant because it intensifies our "sense of living." It

follows that *planned* music programming in hospitals can produce certain predetermined salutary effects that are highly desirable.

At Connecticut State Hospital, for example, there was a high rate of accident occurrence at 6 a.m. This was due, no doubt, to the highly disturbed condition of patients upon awakening from the fantastic and grotesque world of their dreams, added to perfectly normal prebreakfast ill temper. The hospital decided to bring music into the wards from 5:45 a.m. to 6:30 a.m. with the result that accidents were reduced nearly 30 per cent.

The many observed changes in patients' attitudes after the initiation of music makes for interesting discussion but can serve no more useful purpose than the disclosure of the success in combating the cause for which the experiment was initially addressed. This one consideration more than justified the permanent adoption of music.

Bases for Programming

Programming music in general hospitals may be recommended on the following bases:

1. In day rooms, lounges and solariums to provide a distraction from worry and care and create an atmosphere conducive to relaxation.
2. In cafeterias and restaurants to make mealtime a pleasanter interlude.
3. In wards and private rooms for a pleasant diversion during the long day and to induce the evening sleep.

What the introduction of music will accomplish is to obviate the feeling of coldness and sterility too commonly associated with hospitals and to substitute a friendly, homelike atmosphere. Any hospital that considers lighting, ventilation and décor as important factors in hospital administration will find the appeal of music to be irresistible. Dr. Willem Van de Wall recently stated "these activities (music) help, like friendly faces, clean and bright curtains and flowers, to make the hospital environment more livable and encouraging."

Voluntary hospitals, prompted by experience gleaned from the armed services' hospitals, have in many instances been encouraged to undertake a music installation albeit with some timidity and much reservation. In practically every instance, the program ultimately earned enthusiastic endorsement. In the few instances that it was discarded, the cause could be directly traced to careless or improper programming or undesirable methods of music distribution.

Certain basic considerations in hospital music deserve mention. The music should be generally bright and cheerful with emphasis on salon or light concert presentations. Waltzes, popular standard works and new popular instrumental music, appropriately arranged and properly grouped, are valid for daytime. Vocal selections are out of place. In the late evening, restrained chamber music, simply orchestrated, will act as a soporific.

Hospital music at all times should serve merely as background and therefore should be presented at low volume level. Under such conditions, it will not interfere with conversation, reading or with hospital functioning. It should not obtrude. It can be so arranged that the listener may reject the music if he wishes.

It is worthy of note that a leading exponent of the functional type of music is conducting studies of music in hospitals with the aim of realizing optimum results with this instrumentality. Certainly, as valuable a tool as music should not be a subject of compromise. It merits the most careful planning. In proper hands, it can be an effective instrument in hospital administration.

The modern hospital is wisely conscious of its public relations. The reaction to music by both hospital patients and visitors has been favorable. The progressive, efficient hospital can find an immediate job for music.

TB Loses Another Round

DOWN in Memphis, Tenn., where tuberculosis has always been a major health problem and where one of the finest of the National Tuberculosis Association affiliates has waged an intensive and progressive campaign against the disease since 1916, an advanced step toward the elimination of tuberculosis has recently been inaugurated.

Chest x-ray examination of every patient who enters the receiving or outpatient wards of John Gaston Hospital has been adopted and it is thought that this move in the operation of the city-county owned institution will be followed by the city's voluntary hospitals. The chest x-ray measure came about through the combined efforts of the city-county health department and the Shelby County Tuberculosis Society, both of which have cooperated closely toward the ultimate goal of controlling the disease.

According to Dr. L. M. Graves, health department head, chest x-ray examination will soon become as routine in all hospitals as urinalysis and blood count checks have been.

In the John Gaston institution, this case finding operation should prove particularly effective since the type of patients who ordinarily utilize its facilities are from the classes in which the disease has been most prevalent.

Deaths from tuberculosis in Memphis and Shelby County, which area has an estimated population of around 400,000, numbered 220 during 1945. This figure was 50 per cent below the death rate of thirty years ago when the population of the area was less than 150,000 persons. Yet the health official pointed out that the disease is far from the desired stage of control necessary to lower it on the health problem list.

Equipment for the hospital was purchased from state health department funds. Technical and clerical personnel for the operation of the unit and the films required are furnished from the tuberculosis society resources.

These concentrated activities in the war on tuberculosis are especially outstanding in a state that has for years been near the top of the tuberculosis death rate for the United States. A large measure of the credit for the accelerated program is due the society, which in 1946 is spending $72,500 in its fight on the disease.—TOM SPALDING, *public relations director, Shelby County Tuberculosis Society, Memphis, Tenn.*

Can *Doctors* and *Hospitals* Get Along?

This survey indicates that they can and do—but better mutual understanding is needed today

FRANK P. HAMMOND, M.D.

Medical Director
Plan for Hospital Care
Chicago, Ill.

EXCEPT for a noisy minority, doctors understand that hospital administrators have a difficult, complex task to perform and are doing it ably.

Most doctors deplore but are not alarmed by the fact that physician-employes of many hospitals provide certain medical services for patients. For the most part, they think hospitals are not engaged in any sinister plot to gain control of the medical profession. They think Blue Cross is an excellent thing, for themselves as well as for their patients and their hospitals.

No Great Feeling of Conflict

Many hospital administrators, for their part, do not regard doctors as hard to get along with. There is no widespread feeling that conflict between the hospital and the staff is unavoidable on account of the occasional overlap of medical and hospital services. Blue Cross has aided rather than harmed the relationship between doctors and hospitals, in the opinion of most administrators.

These are the broad conclusions drawn from a survey which sampled opinion on these important questions among physicians and hospital administrators across the country. In both groups there were a few who spoke bitterly and forebodingly of conflict and their complaints may be studied with profit, as may also the many specific criticisms included among the observations of those whose judgment in large part was favorable.

This survey was made for the purpose of determining the amount of truth in charges that ill feeling between hospitals and doctors is becoming more and more the rule. Certain evidence seemed to support such claims: Increasingly in the medical press, for example, editorials and articles have appeared referring to the presumed effort on the part of hospital and Blue Cross executives to "control the practice of medicine."

Much the same sentiment has been expressed at medical gatherings in recent months. The author of one such statement went so far as to express a frank preference for government control as against hospital control of medical practice.[1]

On the other hand, some hospital people have more or less openly advocated abolition of medical practice as we know it today in favor of full time salaried staffs for hospitals, which would then become the focal point of all medical care. And the inclusion of such services as radiology, pathology and anesthesiology among the benefits of many Blue Cross plans has long been a subject of heated dispute between contentious members of both groups.

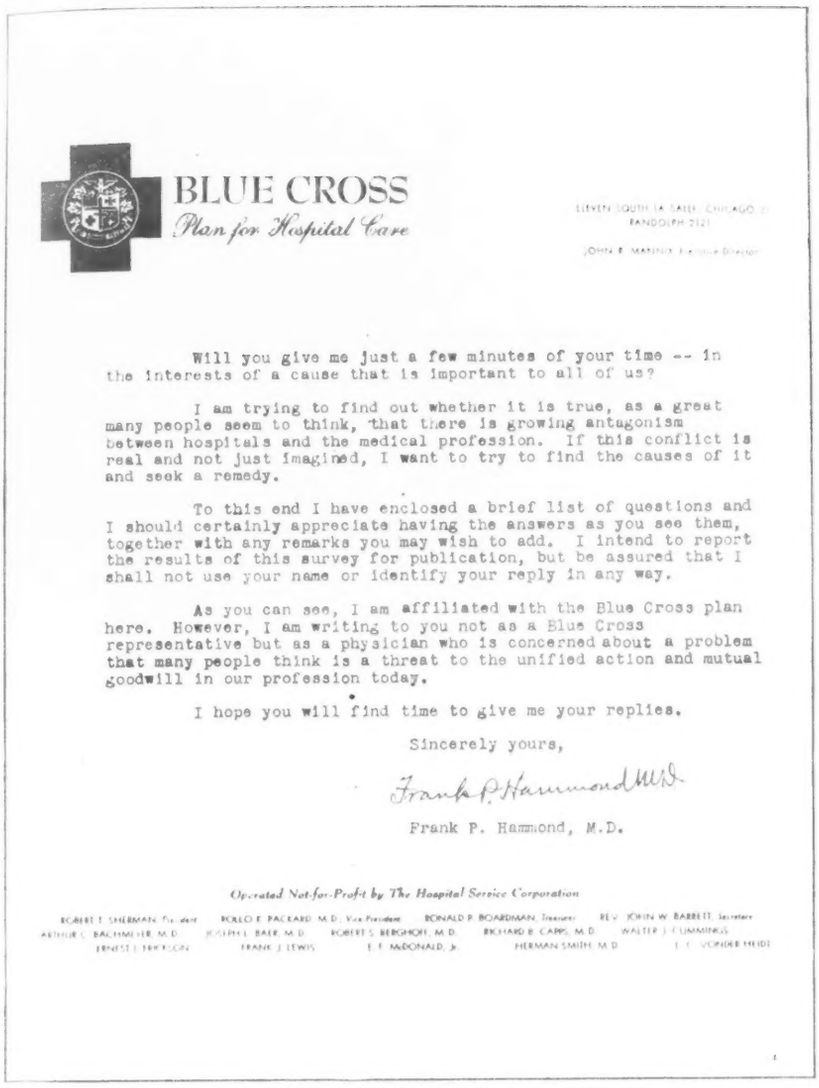
[1] "As between domination by the federal government and domination by hospital administrators, I think I should prefer the former. Unless we are very careful indeed, we are apt to find hospitals dictating the practice of medicine. The trend in that direction may have been unconscious and unintentional at first, but I think it is neither of those things now." The past president of a large state medical society, quoted in the Mississippi Valley Medical Journal, July 1945.

How extensive were these feelings of hostility? How important? How did they affect the relationships of individual hospitals and their staffs, if at all? What, explicitly, were the complaints each group had about the other and what suggestions were there for remedying misunderstandings? These were the questions to which answers were sought in the survey. The results are described here.

Discussion Encouraged

Simple questionnaires were drafted asking bluntly whether any conflict between doctors and hospital existed, what its sources were, what complaints each group had and what remedial steps could be suggested. The questions were framed to encourage informative discussion as opposed to simple "yes or no" answers.

Questionnaires were mailed to carefully selected lists of physicians and hospital administrators. Among the 286 doctors who were queried were officers of state medical societies and a selection of officers of national specialty groups. To make certain that the replies would adequately represent any real antagonism toward hospitals that might exist, disproportionately large numbers of the remaining questionnaires were sent to physicians in such states as Wisconsin, Pennsylvania and Illinois, where the inclusion of medical services in Blue Cross plans has been a source of friction for several years. For the same reason, the list in-



BLUE CROSS
Plan for Hospital Care

ELEVEN SOUTH LA SALLE, CHICAGO 3
RANDOLPH 2121

JOHN R. MARSHALL, Executive Director

Will you give me just a few minutes of your time -- in the interests of a cause that is important to all of us?

I am trying to find out whether it is true, as a great many people seem to think, that there is growing antagonism between hospitals and the medical profession. If this conflict is real and not just imagined, I want to try to find the causes of it and seek a remedy.

To this end I have enclosed a brief list of questions and I should certainly appreciate having the answers as you see them, together with any remarks you may wish to add. I intend to report the results of this survey for publication, but be assured that I shall not use your name or identify your reply in any way.

As you can see, I am affiliated with the Blue Cross plan here. However, I am writing to you not as a Blue Cross representative but as a physician who is concerned about a problem that many people think is a threat to the unified action and mutual goodwill in our profession today.

I hope you will find time to give me your replies.

Sincerely yours,

Frank P. Hammond M.D.

Frank P. Hammond, M.D.

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cluded many more radiologists than any random selection of the same number of physicians would have permitted. The entire group included practicing physicians in every state of the Union.

Hospital administrators were chosen for questioning with similar care to include a heavy sampling from every possible sore spot. The remaining administrators on the list of 191 were selected so there would be adequate representation from all types of hospitals in all parts of the country. The group favored larger hospitals in metropolitan centers as opposed to the small community or rural hospital, since it was felt that the more complex staff organizations in the larger hospitals would be more likely to develop differences.

Completed questionnaires were returned by 136 physicians, or 48 per cent of those queried, and by 127 hospital administrators, or 67 per cent of this group. Certainly, these comparatively high percentages of response indicate a lively interest in the subject on the part of the groups covered in the survey.

Doctors' Replies

Of the 136 doctors who responded, 112, or 82 per cent, said they were aware of no real conflict between themselves and their hospitals, or between their medical organizations and hospitals as a group.

Seven of the physicians who replied indicated that they were in administrative work rather than active practice and thus felt disqualified to respond from the physician's point of view. The remaining 17 doctors, 12 per cent of the group, described some conflict or feeling of antagonism toward the hospital.

In this group of 17 physicians, nine stated that the source of the trouble was the fact that the hospital was practicing medicine: "Don't favor hospital taking over certain medical functions"; "we do not believe the hospital should practice medicine by offering x-ray and anesthesia services"; "like most hospitals they would like to control the practice of medicine"—these are typical observations in this group.

Obviously working up a little heat as he went along, one doctor presented his views in a little more detail. "Let the hospitals supply bed and board and nursing care and get completely out of the practice of medicine in the daily administration of their hospitals," he wrote, beginning on a familiar theme.

"That is a bigger job than most of them have been able to do in the past," he went on. "The practice of medicine is a full time job which takes a physician with a rigid course of education, training and experience and when the all-wise hospital administrator with no medical training at all wakes up to that fact he will perhaps begin to see the light and stick to his own job."

As did several others, this correspondent felt that another source of trouble was the fact that the doctors are not consulted or kept informed in connection with the operation of the hospital. This was named as the No. 1 difficulty by five of the group. Here are some of the ways it was described:

"The management listens very politely to the suggestions of the staff executive council and then forgets to carry out the suggestions."

"The administrator tells you what you can and cannot do."

"The hospital management does not 'use' the staff sufficiently in handling major problems, for example, a recent addition concerning which the doctors were scarcely consulted. The same applies to other matters of importance."

One doctor summed it all up succinctly: "Board appointed woman superintendent," he wrote. "She thinks she owns hospital."

The only other problem that was mentioned more than once in these replies was the one named by three doctors who felt that the hospital was too intent on making or keeping money—at the expense of patients and doctors.

Replies listing such factors as the bed shortage and lack of nursing or other help as sources of conflict were

not included among those counted as indicating antagonism because it was felt that these problems are universal today and do not represent any difference between doctors and hospitals in the sense of this survey.

Nine of the 17 physicians who described some conflict felt that Blue Cross had complicated or hurt the doctor-hospital relationship. "The Blue Cross has to be watched," one doctor warned. "It, like hospitals, tries occasionally to practice medicine."

Blue Cross has harmed the relationship "very definitely," according to another view, "and it is about time the Blue Cross and the American Hospital Association woke up to the fact."

"Failure to utilize representative medical men from medical societies in formulating Blue Cross plans is an outstanding error," another statement declared. "Blue Cross should be part of medical society effort, not independent thereof."

The owner of an x-ray and clinical laboratory described Blue Cross inclusion of radiology services at hospitals but not at his laboratory as unfair competition.

Eight of the 17 doctors in this group think that Blue Cross has not hurt the doctor-hospital relationship. One thinks it has helped.

Twelve of these physicians answered "yes" to the question, "Do you believe that hospitals are deliberately trying to gain control of the practice of medicine?" Four of these indicated that this ambition was restricted to a comparatively small group within the hospital field and was not characteristic of all hospital people. A letter from one of these doctors is worth studying:

"It is very rare that there is any particular conflict between the physician and the hospital in which he works," he wrote. "It is this very thing which makes it so difficult for doctors to realize that their profession is being menaced, since each doctor is accustomed to the friendly and familiar place in which he works nearly every day.

"I am quite sure that the farthest thing in the world from the minds of most hospital administrators and boards of trustees is to do anything to harm the profession of medicine, but I regret that I cannot hold the same position as concerns a small group which, to me, has seemed for a long time to be bent upon domination of the practice of medicine.

"One need do no more than read the editorials in the various hospital journals to realize that this fear is not entirely unfounded: 'The care of the ambulatory sick is increasingly the province of the hospital.' 'Good hospital care includes good diagnostic service and therapy.' 'Shall a group of stuffy little men [the reference is to the House of Delegates of the American Medical Association] tell the trustees of our hospital care plans what they shall do?'

"It seems to me impossible that a thinking physician confronted with such statements as the foregoing should have any doubt that there is a growing antagonism between hospitals and the medical profession. The solution to the problem seems to me rather simple: Let medical care be administered by physicians and hospital care by hospitals."

Of the 112 physicians who responded to the questionnaire saying that no particular conflict existed, 22, nevertheless, listed definite complaints about hospitals other than the common "short of help," or "not enough beds." Five of the complaints were the now familiar "hospital should not practice medicine," and five more felt that doctors should be consulted and heeded more closely in hospital affairs.

Four complained that hospital costs were unnecessarily high, and three said standards were so poor that the hospital was not a desirable place to practice. The remaining five complaints covered a variety of subjects obviously of only local significance.

Only 11 of the 112 physicians in this group felt that Blue Cross had complicated or harmed the hospital-physician relationship. Seventeen of

DOCTORS' REPLIES

Number of questionnaires issued	286
Number returned	136
Per cent response	48
Number indicating "no conflict"	112
Per cent	82
Number indicating "conflict"	17
Per cent	12
Number declining to answer	7

CAUSES OF CONFLICT NAMED BY DOCTORS

Cause	Named by Doctors in "Conflict" Group	Named by Doctors in "No Conflict" Group
Hospitals practicing medicine	9	5
Ignore doctors' suggestions	5	5
Too interested in making money	3	4
Poor standards of service	—	3
Other complaints	—	5

ANSWERS TO BLUE CROSS QUESTION

	Doctors in "Conflict" Group	Doctors in "No Conflict" Group
Number of doctors who think Blue Cross has hurt relationship with hospitals	9	11
Number of doctors who think Blue Cross has helped relationship with hospitals	1	17
Number of doctors who think no harm has been done	8	89
Number who never heard of Blue Cross or don't know	—	12

ANSWERS TO CONTROL QUESTION

	Doctors in "Conflict" Group	Doctors in "No Conflict" Group
Number who think hospitals are trying to control the practice of medicine	12	18
Number who think hospitals are not trying to control the practice of medicine	5	90
Not answered specifically	—	4

SUGGESTIONS FOR IMPROVING RELATIONS

Method Suggested	Doctors in "Conflict" Group	Doctors in "No Conflict" Group
Hospitals stop practicing medicine	5	21
Meetings to promote better understanding	3	26
Put doctors on hospital board	1	6
Give doctors more to say about hospital	4	—
Open hospital staffs	—	4
Improve hospital service	1	8
Provide more beds	—	13
Abolish Blue Cross	—	1

those who believed otherwise added that they felt, on the contrary, that the relationship had been improved. Those who specified that the relationship had been harmed, in their opinion, only because Blue Cross made hospital beds harder to get, were not counted among the 11 who thought the general effect of Blue Cross had been harmful.

Eighteen of the 112 physicians who voted "no conflict" still believed that hospitals were "deliberately trying to gain control of the practice of medicine."

Asked what they thought could be done to eliminate conflict between doctors and hospitals, 21 physicians who had already stated that no such conflict existed said hospitals should get out of the practice of medicine. The same suggestion headed the list of remedies among the 17 physicians who admitted the presence of antagonism.

In both groups, other suggestions for better relations with hospitals included better understanding of each other's problems through joint meetings of board, staff and administrator and other cooperative ventures; putting doctors on the hospital board and otherwise bringing them into closer contact with the management of the hospital; discontinuing the closed staff system, and improving hospital standards and service. Other suggestions were widely scattered and reflected local situations.

Some of the suggestions for improvement of relations and the comments which accompanied them are worth repeating here:

"One of the important problems of the voluntary hospital is to gather sufficient funds so that income will at least equal operating expenses," one doctor wrote. "In most instances this is done by collections from the private patients whom doctors send to the hospital. Therefore, hospitals from a business standpoint should treat doctors as customers would be treated in any progressive business, that is, with consideration and in an attempt to furnish them with up to date equipment and supplies as much as is humanly possible."

"Hospitals easily slip into the practice of medicine by giving x-ray treatments, allergy treatments and frequently hypodermics," another stated. "Sometimes this is done with the knowledge of the physician, but there are times when the physician loses contact with his patient entirely.

"Physicians would do well to examine every bill that is rendered their patients. Then they would understand what hospital service costs."

"Any threat to unified action and mutual good will in our profession today lies not in antagonism between hospitals and doctors, but rather in lack of unity among the doctors themselves," another reasoned. "In the discussions that I hear there are a mounting tension and lack of trust among general practitioners toward the organizations of specialists and the powers these groups are attaining with hospital management. The hospitals are not taking the initiative in this matter but are acceding to what they believe to be measures for the improvement of care of the sick."

"The hospital should be made to realize that it is solely for the convenience of the physician and should be subject to his orders, and not the contrary as now exists," still another stated.

Finally, one doctor added a stern admonition to the author of the questionnaire:

"Now that hospitals begin to fear that they are in the same boat with the medical profession as regards federal control, they are trying to make a common cause with the medical profession, after having created a great deal of ill will by their high-handed actions in the past. If that is the club over your head that is at last driving you to tabulate the factors which have been all too evident in the past, it may be all to the good. But don't color them to your own liking. Face them and apply intelligent judgment before you act any more rashly than you have."

Hospital Replies

Of 127 hospitals replying to the questionnaire, only 22, or 17 per cent, acknowledged the presence of any conflict or hostility toward doctors. The chief reason for conflict, described by 13 of the 22, was that doctors don't understand hospital administration but insist on making their influence felt in administrative matters. A closely related cause of conflict is the complaint made by seven hospital ad-

HOSPITAL REPLIES

Number of questionnaires issued	191
Number returned	127
Per cent response	67
Number indicating "no conflict"	105
Per cent	83
Number indicating "conflict"	22
Per cent	17

CAUSES OF CONFLICT NAMED BY HOSPITALS

Cause	Named by Hospitals in "Conflict" Group	Named by Hospitals in "No Conflict" Group
Doctors interfere in administration	13	4
Doctors are "too individual"	7	8
Abuse hospital facilities	1	8
Neglect records	—	12
No complaint at all	—	75

ANSWERS TO BLUE CROSS QUESTION

	Hospitals in "Conflict" Group	Hospitals in "No Conflict" Group
Think Blue Cross has harmed relationship with doctors	2	9
Think Blue Cross has helped relationship with doctors	7	30
Think Blue Cross has not harmed relationship	20	96

ANSWERS TO CONTROL QUESTION

	Hospitals in "Conflict" Group	Hospitals in "No Conflict" Group
Number who think hospitals are not trying to control practice of medicine	20	104
Number who think hospitals are not trying to control medicine but added qualifications	2	1

SUGGESTIONS FOR IMPROVING RELATIONS

Suggested Method	Hospitals in "Conflict" Group	Hospitals in "No Conflict" Group
Meetings to promote better understanding	8	27
Teach administration in medical schools	1	1
Both groups stick to own fields	1	7
Provide more beds	—	5
Nothing can be done	2	—

ministrators that physicians are "too individual" and do not lend themselves to organization functions. Here are some of the statements made in connection with both these complaints:

"Doctors fail to realize that a hospital is a complex organization and they must be more understanding of various administrative problems and should realize that they are part of a team. They often seem to forget that there must be discipline and organization if a hospital is to function efficiently. Often they tend to be self interested and think only of their own immediate personal consideration."

"Too often they are interested in administrative problems and not enough in staff problems."

"Too many are just good doctors and have no time to be good citizens."

"Doctors are too prone to criticize department managers in the hospital and to listen to individual complaints."

They Won't Observe the Rules

"They do not like to observe hospital rules. Their patients are always more important than another doctor's patients. If you could knock some of the ego out of them and convince them there are other great men in the world, too, perhaps they would get the proper perspective."

"They seem to be guided more by impulse and emotion than by reason at times. I have found that doctors generally are egocentric, interested almost exclusively in matters such as directly concern them or are of immediate benefit to them."

"I know of no other group that has as much fighting and quarreling as the doctors, and they wish to drag the hospital into it. The fighting is among themselves. There are usually two or three groups of doctors and each group fights the other groups."

"They are rugged individualists," one administrator said simply, summing up what many said with more feeling.

Among the 105 hospital administrators who did not recognize any group antagonism, this feeling that doctors are "too individual" was given as the chief complaint by eight, and four more said that doctors "meddled" in administrative affairs.

Eight administrators said that doctors "abused the hospital's facilities," by hospitalizing patients unnecessarily, keeping them in the hospital too long or ordering services out of line with requirements.

The only complaint of 12 administrators was that doctors did not keep their records up to date without a lot of heckling. Seventy-five administrators, 59 per cent of the whole responding group, had no criticism of doctors at all to offer.

Only two of the 22 administrators who recognized some conflict with doctors felt that the relationship had been damaged by Blue Cross, and only nine of the 105 "no conflict" group thought Blue Cross had complicated or hurt the relationship. Of the remainder, 30 administrators added that, on the contrary, they felt the relationship had been improved by the introduction of Blue Cross and five of these stated specifically that the doctors said it was easier for them to collect their own fees when Blue Cross paid the hospital bill.

Not a single hospital administrator believed that hospitals were deliberately trying to gain control of the practice of medicine, although three administrators gave answers of the "no, but . . ." variety. These are of interest:

"'Practice of medicine' must be liberally interpreted," one administrator added. "The hospital is an ideal place for the establishment of special diagnostic aids, such as pathological laboratory and x-ray service. Such service can be furnished to patients more cheaply by hospitals than by doctors because the service is centralized. After all, this service is more or less mechanical and never involves a value judgment *in re* patients. Where the latter is involved there is a pathologist or radiologist to render that judgment."

"I do not believe that hospitals are trying to obtain control of the practice of medicine," another administrator began his reply. "However, more and more medical care is being given in hospitals owing to the fact that doctors are finding it necessary to apply more of their diagnostic and therapeutic measures in hospitals. Often the care of the patient in a hospital is done by the resident and intern staff and the doctor may only see the patient for ten or fifteen minutes a day."

"Most certainly not," declared another reply to the control question. "Doctors who hold this conception are seeing ghosts under the bed. There are, however, certain professional services which can only be rendered by doctors, which have by tradition and custom and public acceptance become known as hospital services and, as such, should be made available to the public and contacting agencies as hospital services. These include laboratory, x-ray and anesthesia services and, provided hospitals reimburse the professional personnel retained for these services by whatever method is mutually accepted and an amount in keeping with incomes of their professional contemporaries, I see no reason for medical personnel as a whole or for individual practitioners to feel that they have lost prestige or intellectual freedom."

Seek Mutual Understanding

Thirty-five administrators suggested that some means must be found for improving mutual understanding between hospitals and doctors. Many thought that frequent joint meetings were the answer. Two suggested that medical schools should include courses in hospital administration so that the next generation of doctors would have a better knowledge of the administrator's problems. Eight felt that if doctors and hospitals would both mind their own business and let the other party mind *his,* all difficulties between them could be ironed out.

Five felt that the situation would remain acute until there was more hospital space so that constant irritations and disputes over the admission of patients could be eliminated. Two administrators felt that hospitals and doctors were simply in inimical positions and nothing could be done to alter this fact or improve their relationship.

One administrator outlined a five point program for avoiding trouble with doctors in the hospital:

"1. Be a good listener.

"2. Tell your story. Give the physician and the staff an opportunity to understand your problems.

"3. Provide a good workshop for the physicians. By providing this, you are assured of a better type of hospital service for the patient. I have never felt that the physician is unreasonable in his demands for cer-

tain types of equipment or service if he is given an opportunity to understand why we cannot always accede to his wishes.

"4. Build up a good medical staff organization. The impetus for this may have to be provided by the administrator or a good committee on which both hospital trustees and medical staff members are represented.

"5. Be content to be an administrator and leave the practice of medicine to the physician. One can hold the reins and in a large measure control the type of medical practice in the institution if he works wisely through and with a medical staff which takes its responsibilities seriously."

The purpose of this survey was to disclose the extent of a putative antagonism between doctors and hospitals and to uncover the causes of the conflict where it existed in hopes of pointing the way to more amicable relations and better teamwork. Actually, the survey has demonstrated that ill feeling between these groups is more apparent than real. Certainly, those who feel hostile are vocal out of all proportion to their numbers; the vast majority of physicians and hospital administrators are working together in good faith and spirit, with only those inevitable small frictions that arise in any closely associated group of human beings.

Nevertheless, the greater part of this report has been devoted to airing the views of the minority. Their views are worth heeding. They have ripped the bandages from the sore spots and revealed them, for the most part, as wounded feelings rather than serious infections. The only problem of real or lasting consequence that comes up from the replies is one that everybody knew existed: The overlap of medical and hospital functions in the matter of pathology, radiology and anesthesia services.

Probably there is no simple answer to the problem these services thrust upon us, but the survey shows that doctors and hospital administrators who are sensible and considerate of each other can live with this problem and enjoy good working relations. If the views of those who are disturbed about the situation point to any one conclusion, it is that doctors and hospital people must work a little at getting along together. Most of their troubles, it is plain, would vanish with a few applications of frank discussion and mature tolerance. Possibly the need was expressed as simply as it can be by the Sister Superior of a Catholic hospital in the Middle West:

"May the enemy of salvation keep such conflicts from us," she wrote across the bottom of her questionnaire. "May the Angelic Peace of Bethlehem keep us working for the welfare of others."

Her prayer is something to keep in mind.

JOB ANALYSIS:

Guide to stabilized employment

LOUISE CARSON
Assistant Director of Personnel
St. Luke's Hospital, Chicago

JOB analysis and evaluation were started at St. Luke's Hospital in Chicago at the time we looked forward to a more stable employment market when help might be less transient. We anticipated longer service records and opportunities for transfer and promotion; opportunities to train our employes better and to build employe morale.

We knew what we wanted, but we didn't have the proper instruments to reach our goal. We wanted complete and current descriptions of every job in the hospital, including the qualifications necessary to fill each job adequately, showing the vacation, sick leave benefits and work week, the salary range from the minimum starting salary to the highest maximum rate for each job, and the salary administration, which is the length of time and merit required to grant increases in wages paid.

Presented at the Tri-State Hospital Assembly, May 1946.

Our basic structure of salary ranges, job descriptions and salary administration had just "growed," like Topsy. Our employe policies had been revised and enlarged so many times that we had grown, not by desire but by circumstance, to be inconsistent. That happened through no particular fault of ours. We blame it on the war.

During the war we suffered terrific turnover; we used poorly trained and inefficient labor; we combined two and three jobs into one, and broke down semiprofessional jobs, permitting nonprofessional workers to help heal the sick.

A job analysis is the hub of the wheel of employe satisfaction and its seven spokes are the uses to which a study may be put. We developed the following seven policies.

1. More Effective Employment System

For instance, with the duties of each job described, including the necessary qualifications and the benefits allowed, our personnel office should be able to recruit and select better candidates. Uniform policies that can be explained at the time of preliminary interview make for greatly improved employe-employer relationships.

2. Organizational Charts and Lines of Authority

With standard, organized and recognized progression of salaries and position responsibilities, we can formulate organizational charts of each department. Each employe from the line worker to the staff member can easily recognize his lines of responsibility and authority.

3. Manual Showing Descriptions of Duties

Each department head has a copy of his department's job descriptions as a work manual; the personnel office and administrator's office each has a complete set of all departmental schedules.

4. Normal Lines of Promotion

This represents another long and arduous task, but certainly it is something to be desired and excellent material with which to build employe morale. The individual and mass satisfaction of employes who know promotions are made from within before outside candidates are presented is fine for them and for the organization.

5. Training and Orientation

The last four or five years have offered no opportunity to train or orient employes. People were not on the job long enough to spend time away from the actual work to be done to learn about hospital purposes, hospital courtesy and consideration and such things as the physical layout of the building. And any training on the job they received was probably given them by someone who also had little or no training in it.

We believe in the merits of orientation and training programs before the employe reports for duty. We make him believe he is an important person to the effective operation of his department rather than just one of 800 employes. Our job descriptions, qualifications and benefits again play an important part in that program.

6. Job Values and Uniformity in Salaries

Certainly, uniformity in salaries is desirable and the reasons are obvious. Different salaries on like jobs will practically guarantee unrest and turnover.

7. Base for Salary Comparison With Other Hospitals in Community

In our first analysis, we made a complete study of each job. In reducing each job to writing, we included the general duties, not in exact detail but enough of a description to explain the work done. In several instances the employes kept a list of each task performed, or the supervisor listed the duties he expected to be performed. From this information we wrote job descriptions.

We brought all old job descriptions up to date; some we eliminated because they were obsolete; others we added as new jobs. We assigned standard job titles and determined each position's requirements or qualifications and then set forth to evaluate the jobs.

Methods of performance and the characteristics required to fulfill the job successfully, based on job requirements, were then determined. Job requirements included the educational background, experience, skills, physical abilities and age.

Job evaluation is actually based on opinion; hence, it is not exact or inflexible. The opinion, therefore, should be based on judgment which is made possible by the uniform application of a common measuring stick. Established job evaluations can determine a minimum wage below which we will not hire unless special conditions warrant.

From our established job titles and groups we classified jobs by similarity of tasks and, secondarily, on similarity of specifications or requirements. We had so many jobs that the task of comparing values and specifications was almost impossible. Our four main groups, finally reduced according to size and likeness, were: (1) manual, (2) clerical, (3) skilled, (4) department head level.

We broke down each of the four large groups into classes, determined by the basic minimum rate for each job. In evaluating our jobs, we made a list of factors which applied in varying degrees to the majority of jobs; not all factors applied to all jobs, but the varying degrees of application helped establish the job rates. We included in our evaluation chart 10 factors: education and experience; personality; physical effort and working conditions; training time; care of property; appearance; personal capacity; initiative; ingenuity and judgment, and supervision of others.

Each of these 10 factors represents 10 points, and any portion of 10 can be allowed each factor so that the highest possible score is 100 points. From these total scores, our old rates and our four large groups, we reduced the monetary picture to four classes:

Class 1. A score of fewer than 30 points has a minimum salary below $125 per month.

Class 2. A score of fewer than 70 points has a minimum salary below $175 per month.

Class 3. A score above 70 points has a minimum salary of $175, up to the appraised positions.

Class 4. The appraised positions, which are the department heads.

There are several breakdowns of minimum salaries within these classes, determined by the actual scoring. The three department heads, for instance, who employ maids, each scored their jobs. The total scores of each were within two points of one another and were below 30 points. That score fell below the $125 minimum scale or into Class 1. All maids were then weighted within that class and now start at $95 per month.

Our secretarial positions were not filled with many inequalities but by scoring we eliminated all discrepancies and have two groups: juniors at $140 minimum to $175 maximum, and seniors at $150 minimum to $190 maximum. All work the same number of hours and have the same employe benefits.

Our completed picture reflected, in addition to our gradings and job descriptions, current wages; comparisons of wages of other hospitals in the community; union scales; surveys by the Council of Social Agencies, American Dietetic Association and some government agencies.

Know Requirements of Each Job

The personnel office and the department heads have endeavored to take the mystery out of our structure and policy. We know the duties and requirements of each job, the salary range and salary administration. Our employes know they do not have to ask for an increase but that they are eligible at appointed intervals for such consideration. If their work performance does not merit that recommendation, they are told why and we endeavor to help them bring it up or, perhaps, suggest a transfer to another job.

Our salary ranges and job evaluations guide us and the employe in merit increases, transfers and promotions. And we heartily believe those three functions of personnel work have drawn and will continue to draw us nearer to stabilized employment, to a better class of labor, to less turnover and to higher employe morale.

A druggist of Newport, R. I., affixes a Blue Cross poster to the entrance to his store during the recent individual enrollment campaign.

A DIRECT ANSWER *to the* Enrollment Problem

STANLEY H. SAUNDERS
Executive Director
Hospital Service Corporation
of Rhode Island, Providence

THE goal of every Blue Cross plan is to enroll as near 100 per cent of the population as possible.

The proponents of federal legislation contend that only compulsory methods will achieve this goal. However, to those in the Blue Cross movement, the idea of compulsion is obnoxious and is justified only if and when voluntary efforts to attain the objective do not succeed.

Obviously, any Blue Cross plan that intends to enroll a high percentage of the population must provide some way for people to join who are not eligible under group enrollment regulations. Of course, it is necessary that this type of enrollment be on a sound actuarial basis in order to avoid jeopardizing the entire program.

In the early days of Blue Cross, some plans permitted individuals to form a group of 10 or more among friends and relatives who were not eligible under group enrollment regulations. This policy proved to be unsound, for the individual who formed the group too often took the easiest way out and approached persons who might be in need of hospital care and therefore inclined to join readily. This experiment failed.

However, as time passed, plans found ways and means of enrolling individuals on a sound basis. Rhode Island's experiment is now sufficiently far along that we believe our results and statistics can mean something to others who are interested in this problem.

On three occasions during the last nineteen months, the Rhode Island Blue Cross has opened its doors to allow persons to join individually who are self employed, unemployed, retired or working where there are 10 or fewer employes and who are under the age of 65. More than 39,000 persons, representing 5.7 per cent of the population, took advantage of these opportunities. Much to our surprise, the results of the third campaign, which was recently completed, far exceeded the two previous campaigns in spite of a greatly diminished market.

Some time ago, the threat of compulsory hospitalization in Rhode Island stimulated Blue Cross thinking on how we could enroll individuals safely. The board of directors decided that rather than offer a direct enrollment plan which was greatly restricted in benefits and which might require a physical examination or a detailed health questionnaire, as had been tried elsewhere, we should provide benefits that were substantially the same as those offered under our standard group plan, including maternity benefits after a seven month waiting period. In order to provide this liberal protection, the cost of membership for an individual was increased from $9 to $12 annually and for the family membership, from $22.80 to $24.

We knew that there were many people who heretofore had not been eligible for membership and who would take advantage of the opportunity but, in our opinion, many of these persons were not the best type of risk. Accordingly, in order to enroll a representative cross section of the population, which would, in turn, reflect a normal demand for hospital care, we decided to use advertising to supplement our publicity. The results of the three direct enrollment campaigns were as follows:

First campaign (2 months)	12,218
Second campaign (1 month)	10,849
Third campaign (2 weeks)	16,421

Before starting the second campaign, we were warned that results would not be as good as the first on the theory that we had skimmed the market of those who would be waiting for just such an opportunity to join. The results, as shown, seemed to indicate the wisdom of this observation. However, in making plans for our third campaign, we decided to do everything possible to reverse the downward trend and to prove to ourselves that a well organized program would bring better results.

In addition to the usual publicity stories and radio and newspaper advertising, we tried several new ideas. The first was to obtain sponsored advertisements from 40 of our accounts, which included utilities, banks and industrial firms. These were run in daily papers throughout the state. The second was to do everything possible to make it easy for people to obtain Blue Cross literature and application cards. Through the cooperation of the Rhode Island Pharmaceutical Association, every drugstore in the state served as an information center. Thus we were able to advertise, "Go to Your Neighborhood Druggist for Blue Cross Literature and Application Cards."

Application Made Easy

The third phase of the program was to open enrollment centers in 14 strategic locations throughout the state during the second and final week of the campaign. These enrollment centers were made available through the cooperation of several public utility and retail stores. The purpose of the enrollment centers was primarily to make it convenient for people to turn in their application cards and payments and, second, to relieve our main office of much of the work that it had handled in the previous campaigns.

We were much impressed by the success of the neighborhood drugstore idea, for all application cards left at drugstores were notched, and a final tally showed that 24 per cent of all applications received were obtained originally through this source. The enrollment centers proved extremely helpful, for 43 per cent of all application cards were submitted through these temporary locations.

The annual income on the 16,421 members enrolled during this most recent campaign amounts to $136,368. Blue Cross spent a total of $5785 on the campaign, which means an enrollment cost of 28.4 cents per subscriber. In view of the higher rate charged, this acquisition cost would seem reasonable.

In analyzing the results, we find that the distribution of subscribers according to individual, husband and wife and family memberships was almost identical for all three campaigns and, in fact, corresponded to the distribution of our total membership. With minor variations, enrollment in the five counties in the state was almost the same in each of the three campaigns and, again, closely paralleled that of our total enrollment.

Our breakdown by occupations showed little variation, except that in the last campaign servicemen's wives represented less than 1 per cent of the subscribers, as against 3.8 per cent in the 1945 campaign. This, of course, reflects the termination of hostilities and the resultant demobilization of service personnel.

The breakdown by age groups indicates that those in the 55 to 65 age bracket represented 11.8 per cent of the total direct enrollment subscribers, as against 7.3 per cent on our group enrollment prior to the direct enrollment campaigns. The percentage of those between the ages of 40 and 54 was less than under our group enrollment and of those between the ages of 20 and 39 was slightly higher.

The percentage of married females between the ages of 20 and 39, which we consider our maternity group, was almost the same as under our group enrollment. The average number of persons per application card was 2.3, which, again, is almost identical with our group figures.

From the inception of our direct enrollment campaign to date, we find that we have paid out 65.3 per cent of earned income. It is true that we are just getting into maternity benefits on the second direct enrollment campaign and it will be seven months before we can expect to provide maternity benefits to those enrolled in the last campaign. However, we feel that the demand will still be within reason and not too far out of line with that of our group enrollment.

Aside from the very satisfactory direct enrollment results, we find that the publicity and advertising used in the campaigns have greatly stimulated group enrollment as well. For the effective date June 1, 1946, the next effective date following the conclusion of the campaign, we enrolled a total of more than 30,000 new members. This figure includes the 16,421 new direct enrollment subscribers and marks the highest single month's enrollment in our history. On July 1 we added approximately 28,000 subscribers. To put it another way, in two months we enrolled 8.3 per cent of the state's population.

Many people who are eligible under a direct enrollment program are those whose incomes are relatively fixed, such as persons who are retired, self employed or working in small businesses. To these people, rising hospital costs and charges make it more important than ever that they have the security of Blue Cross protection.

Likewise, it is important to the hospitals that these persons have the opportunity to budget in advance for unexpected hospitalization. Otherwise, those on a fixed income, who in the past may have been able to pay a hospital bill, are likely to find it much more difficult, if not impossible, to pay for the increasing cost of hospital care.

When we started our first direct enrollment campaign using paid advertising, we had two fears, both of which have been answered to our satisfaction. The first was that paid advertising might eliminate or reduce our channels of free publicity, and the second was that the doctors and hospital trustees might not consider advertising dignified. It is our experience that the newspapers have been more generous than ever with publicity and, in addition, we have had the added effect of many of our groups sponsoring Blue Cross advertisements at their own expense.

Their Fears Were Groundless

Not a single complaint has been registered as to the type of advertising or the expenditure of subscribers' money for this purpose. Consequently, we feel that the results most certainly justify the use of this modern method to achieve our objective of service to a greater number of people in a shorter period of time than we thought possible.

Now that we have more than 425,000 persons, or 61 per cent of the state's population enrolled, it would seem that we are faced sooner or later with a saturated market. On the other hand, it is our experience that the last 100,000 subscribers were by far the easiest to enroll.

With the plan now so popular with so many people, we feel that we can go even farther. It is our hope that we can ultimately enroll 75 per cent of the state's population, possibly even more. However, we could never hope to reach such a high percentage of the population unless we provided a direct enrollment plan.

The Case of Dietitian *versus* Hospital Field

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Paterson General Hospital
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ELEANOR FERGUSON
Seattle

MARY deGARMO BRYAN
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THE second section of the study made to determine the reasons for the "disappearance" of dietitians from the hospital field consisted of questions concerning a limited number of labor policies. Every employer is now acutely aware of the demand of employes for security as expressed in good pay, fair working hours, provision for retirement, protection of health through some plan of medical care and hospitalization, sick leave and vacation.

The modern executive realizes that satisfactory provisions on these points make for the stable working force, good morale and minimum of absenteeism which are essential for the smooth functioning of an organization and are apart from the interest and concern which the employer may be expected to have in the individual employe and his problems.

Wages. The question as to whether wages paid to dietary department employes are equal to, less than or better than those for similar jobs in the community was not answered by 50 per cent of the hospitals. Of those that did reply all state that their wages are lower. The lack of response is probably as significant as the fact that hospital wages seem to be below community rates if it suggests indifference to basic information concerning one primary cause of labor turnover.

Pay Equal Wages

Approximately 90 per cent of all hospitals replied to the question comparing wages of dietary department employes with those in other departments in the institution. Seventy-five per cent state that wages are equal for similar work. Ten to 14 per cent in the three groups indicate that dietary wages are lower.

Hours. Total working hours per week for skilled, semiskilled and unskilled employes range from forty to sixty in group A, from forty-four to fifty-six in group B and from forty-four to fifty in group C, while the median for all groups is forty-eight. Work weeks are longer in group A; 16 per cent of hospitals in this group work employes more than forty-eight hours. In groups B and C, 10 and 6 per cent of the hospitals, respectively, work employes more than forty-eight hours.

Spread of hours shows a range of eight to 13 in all groups with 12 the median in A and B and 10 the median in C. An eight hour day is reported in 16 per cent of group A, 33 per cent of group B and 50 per cent of group C.

Retirement. Provision for retirement is made for both professional and nonprofessional employes in but 3 per cent of the small hospitals; however, 7 per cent report that they make informal arrangements when feasible and 3 per cent have plans under consideration. Seven per cent of group B indicate retirement plans for professional workers, 10 per cent for nonprofessional. Group C is largely represented in this study by public institutions and 42 per cent of these report retirement plans for both professional and nonprofessional employes. Nineteen per cent make informal arrangements and 50 per cent have plans under consideration.

Unemployment Insurance. Unemployment insurance was not reported by any institution.

Health Insurance and Hospitalization. Three per cent of small and medium sized hospitals and 10 per cent of the large institutions provide health insurance for both professional and nonprofessional workers. Hospitalization insurance or some hospitalization plan for which employes pay is reported in 45 per cent of the small hospitals, in 19 per cent of the 200 to 500 bed group and in 29 per cent of the large group. Hospitalization is furnished without cost in 48, 57 and 63 per cent of groups A, B and C, respectively.

Sick Leave With Pay. The great majority of hospitals in all groups give sick leave with pay. In the smallest institutions, 93 per cent give sick leave to professional employes and 79 per cent, to nonprofessional. In group B 100 per cent and in Group C 95 per cent give sick leave to all employes.

More than 50 per cent of all hospitals give two weeks' sick leave for both types of employes. This is the maximum period for nonprofessional employes in Group C. In Group B, 4 per cent allow three weeks and 7 per cent allow four weeks for these employes. Fourteen per cent of C, 10 per cent of B and 31 per cent of A allow one week only.

Sick Leaves Lengthened

There is a pronounced trend toward lengthening sick leave for professional staffs. Thirty-three per cent of C, 30 per cent of B and 9 per cent of group A allow three or four weeks, but 5, 10 and 28 per cent of C, B and A, respectively, give only one week.

Approximately one third of the institutions in all groups indicate that time allowed for both nonprofessional and professional employes varies with length of service. Three months is the minimum time required before granting sick leave.

Vacation. Eighty-seven per cent of the hospitals in groups A, B and C give from one to two weeks' vacation to nonprofessional employes: in groups A and B, 62 and 67 per cent, respectively, give two weeks; in group C the situation is reversed and 76 per cent give but one week to ten days.

Although there is variation as to length of vacation, professional employes in hospitals in groups A and

C report that less than two weeks is given to any professional worker. Twenty-eight per cent of A, 16 per cent of B and 33 per cent of C report vacations of two weeks; 3, 13 and 14 per cent give three weeks; 31, 66 and 29 per cent, four weeks; 7 per cent of A give more than four weeks.

Some hospitals suggested a sliding scale which might apply either to type of employment or to length of service. In addition to the hospitals that give specific vacations listed, 10 per cent of A and 14 per cent of C report a scale of from two to four weeks; 21 per cent of A and 5 per cent of C report a scale of from three to four weeks.

Reasons for Turnover

It is evident from replies on these selected labor policies that there may be reasons for the turnover which is so discouraging to dietitians. These findings seem to confirm the opinion that for too long a time many hospitals have paid wages too low to attract or to hold competent workers.

It is also evident that, with the exception of some public institutions, there is but little effort made to provide the social security insurance which the worker would have in any commercial position. It is not possible to compete for first class employes without protection equivalent to this insurance and hospitals are seeking to remedy the situation by requesting inclusion in the federal social security programs.

Good practices are now widespread in hospitals of all three groups regarding hours of work, sick leave and vacations. These equal or exceed policies in other types of food service. Hospitalization is also provided in one way or another in the great majority of institutions; this is to be expected since hospitalization has for many years been one of the inducements for working in hospitals at wages below current community scales.

Summary and Suggestions. 1. It is evident from our study that hospital administrators are faced with the necessity for establishing sound, reasonable and attractive personnel policies in dietary departments, as regards both staff and employes. These policies should be set, if possible, on regional bases after careful joint study of all factors by such groups as the American Hospital Association, the American Dietetic Association, other hospital professional groups and representatives of employment agencies and outstanding personnel departments.

Hospitals should set the standard for the best personnel policies in the community in regard to fair wages, protection of the health of workers, good equipment, safe and sanitary working conditions and training programs to improve standards and to serve as incentives to ambitious workers. The wage scale should certainly be a matter of study and adjustment by administrators in each community.

The basis for the establishment of desirable wage rates is careful job classification, with the establishment of skills and abilities required for each job. The assistance of teachers in food trades vocational high schools and personnel directors in the restaurant industry who have been working along these lines should be enlisted. It is also desirable to use vocational schools as sources of trained employes and to consider the development of employe training programs in connection with such schools.

2. Following the establishment of policies in which the hospital and the community may take pride, a campaign of suitable publicity should be carried on to acquaint the public and possible personnel with the opportunities, responsibilities, dignity and prestige of hospital work.

3. A complete job analysis of the work of dietitians in hospitals of all types should be undertaken by a national committee representing administrative, medical, nursing and dietary groups together with experts in making job analyses. Such a project should warrant the support of a foundation in public health.

On the basis of this analysis, recommendations for training and qualifications of personnel for all aspects of the work should be established. These should include recommendations for fully trained dietitians, as well as for employes whose responsibilities require less training. For example, some work now done by fully trained dietitians could be done with interest and enthusiasm by persons with training in the technical institutes planned for or already established in many states; dietetic aides did much excellent work of this type during the war.

Such a study should also reveal the inadequacies in training of many dietitians and should greatly strengthen the work in colleges and student training courses. It should aid in the selection and vocational guidance of students interested in the hospital field.

It should also show possibilities for in-service training to develop experts in various dietary department activities and for exchange of assistants among institutions so as to broaden their experience.

4. Literature of a vocational nature prepared by the American Dietetic Association has been available for some years but an active recruiting program for hospital dietitians should be begun at the high school level. One such program is underway.

5. Because it is unlikely that there will be enough dietitians to supply demands in the near future it is suggested that advisory services on all aspects of hospital dietary work be established by the American Dietetic Association in cooperation with the American Hospital Association and interested medical groups. This service should be offered on a regional basis if possible.

Service for Several Hospitals

6. The possibility of several small institutions uniting to employ one well trained dietitian who would divide her time among them should be considered. In this way every hospital, regardless of size, and every patient may have access to the best service available. This type of position would interest able dietitians who are unwilling to remain in small hospitals because of salary.

7. On the shoulders of hospital administrators, hospital dietitians and college teachers, and probably of parents and teachers in secondary schools as well, rests the heavy responsibility of again establishing service to others as a goal.

This aim is inherent, even if unrecognized and unadmitted, in all youths. Many young persons and many older ones hope for something great and good to do with life. Without cheap sentimentality and without exploitation, the hospital can offer such a field. There can be no lack of sincerity, however, and the example must be set at the top; an organization is the "lengthened shadow of a man."

PEOPLE IN PICTURES

Students and faculty of Colby College institute on hospital administration. The faculty members were, bottom row, left to right: Dr. Frederick T. Hill, president, Maine Hospital Association; Agnes Gelinas, R.N., chairman, department of nursing, Skidmore College; Helen Dunn, R.N., director, division of public health nursing, Department of Health and Welfare; Raymond P. Sloan, editor, The Modern Hospital; Elizabeth S. Bixler, R.N., dean, Yale School of Nursing; Dr. Claude W. Munger, St. Luke's Hospital, New York City; Edith Patton, R.N., assistant editor, American Journal of Nursing; H. Lenore Bradley, R.N., New York State Education Department, and Frank Wing, director, New England Medical Center, Boston. Second row, center, Pearl R. Fisher, R.N., superintendent, Thayer Hospital, Waterville, Maine; second row, right, Mary E. Curtis, R.N., director, Colby College School of Nursing.

Personnel-ities at the Chicago institute: Above, left to right: Oswald Daughety, Hermann Hospital, Houston, Tex., and Robert Hudgens, Hospital of the Medical College of Virginia, Richmond; Cora E. Gould, New Jersey Orthopedic Hospital, Orange, N. J.; Gordon Friesen, former administrator at Belleville, Ont., now on terminal leave from the R.C.A.F.; John H. Olson, Richmond Memorial Hospital, Staten Island, N. Y., and Ritz Heerman, California Hospital, Los Angeles. Left: Marion Pierce, St. Luke's Hospital, Chicago, and Jane Carlisle, St. Luke's Hospital, Cleveland. Right: James Stephan, Aultman Hospital, Canton, Ohio, and Harold C. Mickey, Duke Hospital, Durham, N. C.

Convention Bound? Of Course

Here are a few suggestions on how to get the most out of Five Days in Philadelphia

RAYMOND P. SLOAN

CONVENTIONS, like most things, offer returns in proportion to what we give to them. To some they bring renewed faith, fresh courage and ambition, broader horizons, new friends; to others, they bring hangovers principally.

Which is it to be? Only we as individuals can answer that question.

Assuming that the great proportion of us are moderate in our tastes and habits, that we look upon conventions and meetings as refresher courses necessary to our professional advancement, there remains the matter of so budgeting our time and strength as to accomplish all our aims.

Too Many Meetings per Person

First, let's do some planning. Studying the program in advance should enable us to find out precisely what is what. More than likely we shall wish we were three instead of one because there is so much that we want to take in that we cannot hope to do. This calls for selectivity.

Between accounting procedures and nursing, for example, which shall we choose? With some deliberation, suppose we check nursing. After all, we have our professional journals on which we can depend to supplement our personal coverage of the various sessions.

Soon we shall probably reach the conclusion that we cannot possibly sit in at all the sessions we have marked and have time for the personal contacts we want to make in and around the exhibits and hotels. At this point let's heed a word of caution. Instead of jumping from one meeting to another in the hope of gathering a thought here and there, better concentrate on a preferred list.

Through the process of elimination, then, our daily schedule assumes a reasonable form, including, in addition to morning and afternoon sessions, time for professional and social contacts, luncheons and banquets, with adequate opportunities for browsing around the exhibits and talking with manufacturer friends.

As we turn each page of the program, pencil in hand, we should attempt to determine whether in the particular sessions we have chosen we may hope to find the answers to our specific problems. What are some of these specific problems? How about reaching for pad and pencil and jotting them down? Somewhere we shall undoubtedly find periods open for discussion or round tables. Why not turn in these questions? Others may be seeking the same information and guidance.

By this time we are probably impressed with the fact that "conventioning" is hard work, a drain upon one's strength and energy, to say nothing of one's feet. We know now precisely what we want to get out of the meeting. The next question is how to accomplish it.

Our schedule informs us that we have certain sessions to cover which take place in a definite hall at a specific hour. Why not be forehanded and gain some idea of the exact location so that at the last minute we shall not find ourselves wandering all over the lot and finally arriving breathless when the first speaker is trying to get under way?

Also, instead of hanging about the door as though speculating whether or not it is worth while to enter, why not walk in purposefully and select a chair well up front so that we can hear what is going on? It is no compliment to the speaker to have his audience congregate around the exits or at the back of the room as though ready to flit at any moment. It is tough on his vocal equipment, too. Yet how many times it happens that with rows of empty chairs up front someone in the rear of the room will call out: "A little louder, please."

Let's make sure that we come prepared with program, paper or notebook for jotting down notes, and a pencil or pen that will write. This obviates borrowing such items from our neighbor who is trying to assimilate what is being said. Our arrival on scheduled time also precludes the need for inquiring in a stage whisper: "Do you happen to know who it is that's speaking?"

How to Torture the Speaker

Conversation or chatter either within the room or about the doorway is only one way in which we may heckle the speaker unconsciously, but effectively. There is the custom of waiting until a new speaker is announced and, having heard his introduction, to walk out on him, as much as to say, "Having waited to see what you look like, I'm on my way."

There is, too, the insidious practice indulged in by some women in the audience of sitting quietly, plying their knitting needles and nodding their heads in approbation—or from drowsiness, who can tell? In the event that drowsiness does become insurmountable, which can happen because of either the heavy air or the heavy speaker, let's be courteous enough to wait until he finishes and make a graceful exit before the next speaker is announced. There is such a thing as convention etiquette and by practicing it we shall be helping ourselves and others at the same time.

Above all else, let's have no part in the general exodus that takes place when the program exceeds its time limits, leaving the last speaker with a handful of listeners. The fault is not his; it is the chairman or the program committee that is to blame for not insisting that each speaker be given a time allotment

and that he stick to it. It is only a matter of courtesy to one who has gone to the effort of preparing a speech to hear him through.

We are attending a particular meeting, it is assumed, with the purpose of gaining information that will be helpful to us in our work. We want to absorb as much as we can. That is why we are sitting comfortably up front, with pencil and notebook waiting.

Suppose we listen attentively, but let's not write too much. The more we write, the less we listen. There is no need to take down the speaker's exact words. What we need to get is his meaning. So let's forget about the notebook for the time being, other than for jotting down any figures or specific phrases which may serve as reminders to our always unpredictable memories, and listen with all the powers of concentration we possess.

Then at the earliest opportunity let us try to write down the gist of his message, with emphasis upon particular points that seem pertinent. It isn't what we bring back with us in our notebooks that measures the success of our participation in conventions and meetings but what we bring back in our heads. The one process should supplement the other. If any corroboration of impressions gained is needed it will be found in the coverage of the meetings appearing in the professional journals.

Audience Must Participate

Much of the success of any meeting depends, of course, upon the speaker and the chairman or coordinator. At the same time there rests with the audience the definite responsibility not only of practicing such courtesies as those described but of participating in discussions which may follow each talk or be postponed until the end of the program. Nothing is more disheartening to those on the platform than a lethargic audience, one that remains stubbornly mute. It is hardly conceivable that the average speaker can have answered every question.

This suggests another use for our notebooks. As each speaker proceeds, why not jot down points which he has not made entirely clear or which we would like to have amplified? If for some reason known only to ourselves we are reluctant to voice these audibly, it is always possible to send them to the chairman or presiding officer by messenger. Most speakers are not annoyed by questions; they feel flattered to have aroused sufficient interest to promote discussion.

We have no need to refer to our daily program to recall that certain hours are assigned to the exhibits. If our advance planning has been accomplished properly, we shall probably have numerous memos of manufacturers' representatives and products we particularly want to see. In addition to specific ports of call, we shall want to wander from booth to booth, again with notebook in hand, to obtain an overall view of "what's new." This cannot be accomplished in merely one trip. Again there is the matter of convention etiquette. It isn't fair to engage any exhibitor in too long conversation if others are waiting to see him. We can always return at some other time or possibly make a definite appointment.

It is to be hoped that we have left sufficient time for social contacts, informal chats in and about the hotels with others in the field. It is from such sources that we frequently gain the greatest help and inspiration, and the severest headaches and hangovers, too, depending upon our individual interpretation of what a conversation should mean to us. In passing, it might be observed, however, that the good fellow of the night before can be a pretty poor fellow the following morning, also that news and rumor travel fast, particularly when it is bad news or ugly rumor.

Let Head Save Feet

Time is drawing short. "How are your feet holding up?" is a question heard frequently. To which the answer is "barely." By this time, however, it should be possible to do less footwork and to start formulating impressions from notes and memory that will constitute that report which we shall be submitting to the board of directors and the department heads. By this time, too, it should be possible to ascertain whether or not all of the questions we brought with us have been answered. If not, there may be another round table. If we don't get what we want there it will be just too bad.

The trip home affords further opportunity to view the various meetings in retrospect. Our notebook is full indeed, not with what individuals have said in detail, but with our own impressions of present day trends and thinking.

So back at our desk again.

"Tired?" inquires the president of our board suspiciously, as he sticks his head in the door.

"Never felt better in our life," we reply enthusiastically.

"Been to a convention, haven't you?" he adds, puzzled. "What, no head or anything?"

"Sure, a head-ful of brand new ideas," we proclaim proudly handing him our report. "Here, read for yourself."

Convention Facts

PLACE: Philadelphia Convention Hall (CH), Bellevue-Stratford Hotel (BS)

TIME: Monday, September 30 to Thursday, October 3

EXHIBITS: Open 9:30 a.m. Monday, CH

GENERAL SESSIONS: 2 p.m. Monday, CH, and 9:15 a.m. Tuesday, CH, Report of Commission on Hospital Care; 9:15 a.m. Wednesday, CH, and 9:15 a.m. Thursday, CH, Staffing the Hospital

HOUSE OF DELEGATES: 8 p.m. Wednesday, BS

PRESIDENT'S SESSION: 8 p.m. Monday, BS

INTERNATIONAL DINNER: 7:30 p.m. Tuesday, BS

SECTION MEETINGS: 2 p.m. Tuesday, Wednesday and Thursday, CH

GENERAL ASSEMBLY: 8 p.m. Wednesday, BS (following House of Delegates)

BANQUET: 7 p.m. Thursday, BS. Induction of new president

SMALL HOSPITAL FORUM

Education Has Many Angles

Courses, institutes and conventions are all part of the administrator's education—and so is his work

FORMAL courses in hospital administration and short term institutes on specific phases of hospital operation are a great help to administrators of small hospitals and should be continued and expanded, a Small Hospital Forum on administrative training quite clearly indicates.

Suggestions for subjects to be covered in institutes and for improving the educational value of hospital conventions were made by several of the administrators participating in the forum.

Twelve administrators were polled in this survey, including four who were nurse executives before taking over their administrative responsibilities; one doctor, and four businessmen administrators. The remaining three did not state what their background had been. Five members of the group served some time in administrative assistantships prior to assuming their present jobs, one was a member of the hospital's board of trustees and six stepped into the top job without having had any specific preparation.

Only one member of this group had attended a full course in hospital administration. A woman with twelve years' nursing experience, this administrator feels that her course has been definitely helpful. Five others have attended one or more institutes, and all these believe this training has assisted them to perform their duties competently. Of the six who have had no formal training, all but one acknowledges the need for some such educational program.

Further Training Needed

Asked specifically in which of the various subjects involved in hospital administration they need more training, most of the administrators responded with several suggestions. Public relations headed the list with seven mentions; personnel and general business methods were named by six each, and accounting was listed five times. Four feel the need for more familiarity with medical terminology and subjects and three want more information on nursing. Laboratory technics, pharmacy procedures and purchasing are other topics included in these lists.

All 12 attend hospital conventions regularly. Ten of these believe that conventions serve a worthwhile educational purpose. One of the remaining two states that she finds conventions stimulating and inspirational but lacking in educational value, and the other qualifies his answer by saying he finds them educational only "to a degree," because there seems to be "little opportunity for the person representing the

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT	BEDS
Honokaa Plantation Hospital, Haina, T. H.	C. L. Carter, M.D.	45
Alamosa Community Hospital, Alamosa, Colo.	H. Niermann	47
University Hospital, San Juan, Puerto Rico	Ruth Allene Mercer, M.D.	60
Rockville City Hospital, Rockville, Conn.	Emma B. Smith, R.N.	65
Hahnemann Hospital, San Francisco	Thomas P. Langdon	78
St. Andrew's Hospital, Minneapolis	Esther Wolfe	80
Marlboro Hospital, Marlboro, Mass.	D. W. Rice	85
Eliza Coffee Memorial Hospital, Florence, Ala.	R. C. Barnes	86
Deaconess Hospital, Freeport, Ill.	Harry D. Keller	92
	Unsigned	98
Wausau Memorial Hospital, Wausau, Wis.	Olive Graham	120
Yorkton General Hospital, Yorkton, Sask.	John Smith	135

small hospital to express himself or find assistance with problems common to the smaller institutions."

Making suggestions for improving the educational value of conventions, four other administrators say they would like to see more help brought to bear specifically on the problems of the small hospital, either through meetings devoted especially to them or by forums, conferences or round table discussions limited to their field. Another wants fewer meetings and talks devoted to generalities and more concentration on specific administrative problems, and one says crisply, "New faces in leadership needed to attain new and interesting ideas." Five of the group have no suggestions for improving conventions.

General Education Helpful

Apparently, the feeling is fairly widespread that general education at the higher levels is helpful in hospital administration. Only four of the administrators queried are college graduates, and five of the other eight say they would be better off with more education.

"General education prepares the mind to meet a variety of circumstances," comments one administrator who is, in fact, a Ph.D. "I know that a college education would have been of great help to me at the time I went into this work," another observes.

"Education is continuous and always of value," says another. "In addition to formal education, I think greater opportunities for associating with outside groups, such as service clubs and the general public, are a helpful part of the administrator's education."

No clear-cut picture of the practical experience that an administrator needs comes up in this forum. The replies were about equally divided between those who feel they needed more practical experience at the time they became administrators and those who are aware of no such need. Except for the obvious fact that administrators who have been nurses feel more at home with hospital procedures than do those who come in from outside the hospital field, no conclusion can be drawn from the previous experience of this particular group.

One administrator states in her reply to the forum: "As many another has, I became an administrator by chance—took a position as superintendent of nursing service, then was made administrator at insistence of board. Have been in this position twenty-three years."

Ten of the 12 administrators think that the trend toward more formal courses and institutes would bring about beneficial results for the field as a whole. One answers this query with a cryptic "Perhaps," and another adds: "Any educational venture should bring beneficial results, but I doubt the advantage of such courses as these over general education."

Suggestions for improving the quality of hospital administration generally range over a wide variety of activities, from correspondence courses in administration to study of psychology and doing a stretch in the business world. Most of the administrators, however, stress the value of institutes, such as those now given, and suggest that more subjects be added and more efforts be made to increase attendance at those already established.

VOLUNTEER ACTIVITIES

—Who Help Themselves

Women's groups present hospitals with no end of labor saving devices for staff and employes but this is a report of an auxiliary that presented a hospital with a device to save labor on the part of its own members.

For years the Woman's Auxiliary of Evanston Hospital, Evanston, Ill., addressed the envelopes in which the *Pilot,* the hospital house organ, was mailed to a long list of hospital patrons. Later the girl scouts helped in this time consuming task.

Recently the auxiliary presented the hospital with an addressograph. There has been a big speed-up in the mailing and volunteer time can be diverted to other tasks.

Business Is Brisk

Tea rooms and gift shops continue to be profitable adjuncts to hospitals. The Open Door is a combination tea room and gift shop run by the guilds of the Hospital of St. Barnabas and for Women and Children, Newark, N. J. That it is a successful business concern may be seen when its chairmen, Joan Hay Rock and Margaret G. Spurr, report that the shop has been able to turn over series G government bonds with a maturity value of $9000 to the hospital toward sorely needed new hospital buildings. The $9000 represents three years' savings; meanwhile, however, the shop has given monthly aid to the social service department and the arthritis clinic.

On the Seventh Day

A religious committee that provides a Sunday service for all patients who are able to and care to attend is just one of the numerous activities of Hahnemann Hospital Association, the women's auxiliary of Hahnemann Medical College and Hospital, Philadelphia.

It has a purchasing committee as well, and a busy group it is. Last year it bought the hospital an electrocardiograph machine, furnished a recreation room for the nurses, supplied ash trays for all private rooms, bought a book cart, furnished a waiting room for the student nurses' health clinic, supplied decorated shades in the pediatric ward.

Other committees are those in charge of the cooperative shop, the beauty shop and the gift shop, those that give aid to the occupational therapy and social service departments, and the mailing and membership committees.

Hours Grow Into Years

The men are still faithful to Middlesex Hospital, Middletown, Conn. The Men's Volunteer Corps is now well into its third year with 11 of the original 28 M.V.'s still functioning, as well as other "graduates" of later classes. The men hold regular meetings during the year, bi-monthly usually, have a director and associate director and give awards for service. At their meetings a talk on some medical subject is given by a member of the professional staff.

In addition to their work of scrubbing floors and washing instruments in the operating rooms and giving ambulance and orderly service, the men volunteers carry on some of the same jobs at Middlesex that the women's groups handle, such as folding linen, cutting gauze and making plaster bandages.

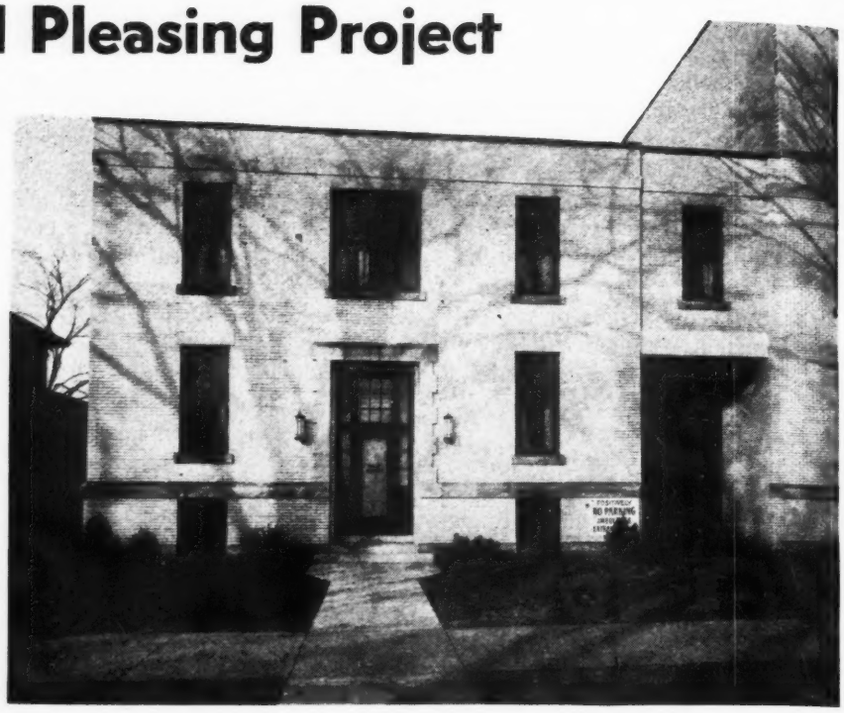
This hospital has two fairly new groups of volunteers, the junior auxiliary and the ward secretaries in the operating suite. Last year the volunteers, all told, gave the hospital about 26,000 hours of free service.

A Colorful and Pleasing Project

Nurses' Home General Hospital of Syracuse

CARL P. WRIGHT

Administrator
General Hospital
Syracuse, N. Y.



THE nurses' school and residence building of the General Hospital of Syracuse, N. Y., constructed in 1944, completes the building program of the hospital, started in 1941, wherein the facilities were increased from 110 to 170 beds and the original plant was remodeled and modernized at a total cost of approximately $600,000, of which $450,000 was raised by a capital fund campaign in 1941.

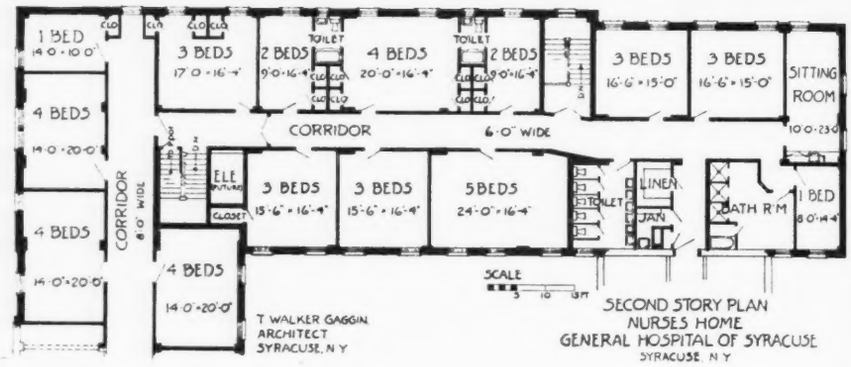
The school and residence building was financed by an 85 per cent federal grant under the Lanham Act with the hospital furnishing the balance. Originally estimated to cost $174,000, it was constructed and equipped for approximately $150,000 under the supervision of the Federal Works Agency.

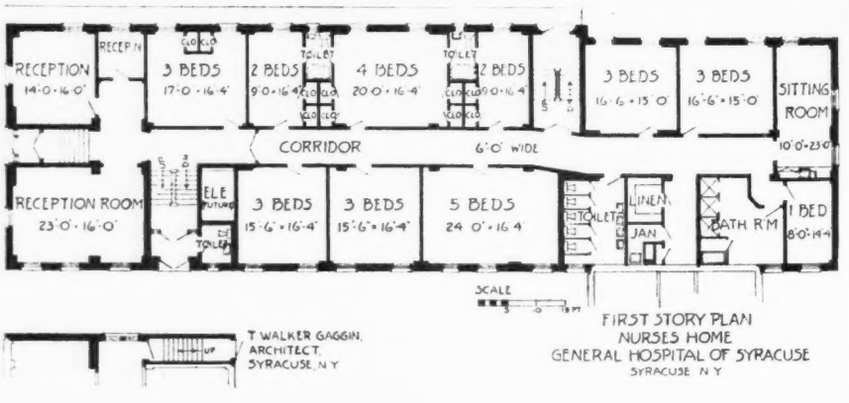
The building consists of a basement and two stories of reinforced concrete construction with foundations designed to carry two additional stories in the future.

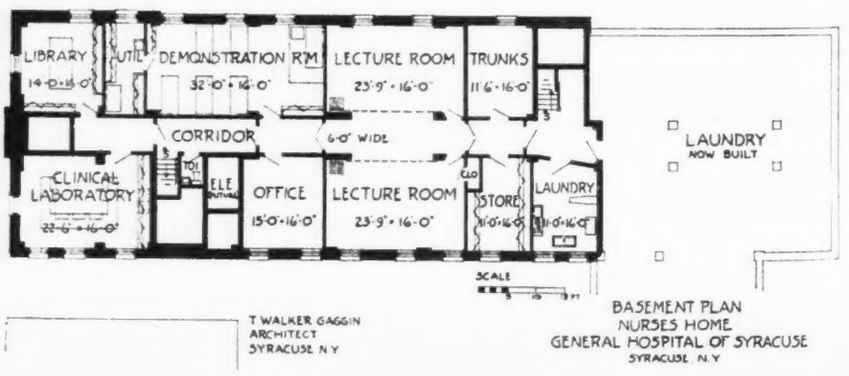
Forms a Quadrangle

It is 145 feet deep, 42 feet wide, located on the south end of the hospital property, connected to the hospital building basement, first and second floors on the western end and to the second floor on the eastern end, forming a quadrangle with a covered driveway into a paved court 52 by 90 feet. It was designed by T. Walker Gaggin, a Syracuse architect.

School facilities are centered in the basement where the library, science laboratory, practical arts laboratory, office and two lecture rooms are located. The lecture rooms are arranged with folding doors to per-







mit their use as two small rooms or one large assembly room. A trunk room, storage room and small laundry for the students complete the basement layout.

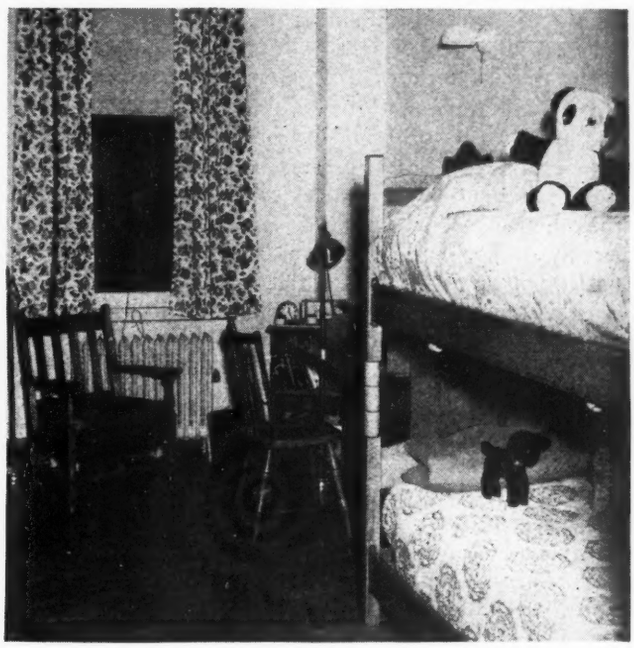
On the first floor, in the front of the building are two reception rooms and an office for the house mother. West of this suite, shut off by a fire door, are the student residence rooms, one, two, three and four bed, with a total capacity of 28. At the western end of the corridor is a clubroom, equipped with kitchen cabinet, electric cooking plate, radio, easy chairs and divans, where the students may lounge and enjoy themselves.

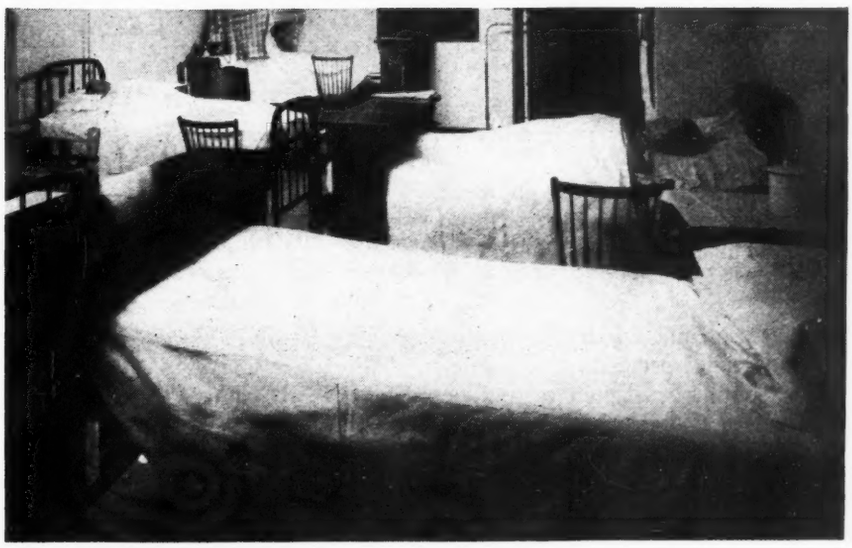
The capacity of the second floor is 41 beds because of the additional rooms across the front of the building over the driveway and the first floor reception suite. The 13 additional beds are so arranged that in the future they can be used for hospital patients, if so desired. This floor also has a lounge room at the western end of the corridor.

The cadet nurse program required the maximum of residence accommodations; therefore the architect designed two, three and four bed rooms. However, he laid out the plan for single rooms and located the doors for them. The contractor erected the wooden door casings in the walls so that, should it be desirable to change to single rooms, it will be a simple matter to remove the cinder blocks and plaster in these openings and install the doors.

The corridors throughout the building are treated acoustically and wooden oak block floors were used except in the front unit on the second story where the hospital rubber floor was continued.

The furniture is wood. The beds in the multiple rooms are double deckers, so built that they can be taken apart and used as singles. The color scheme, painted walls and draperies, completes a very satisfactory and pleasing project.





Opposite page: Exterior and plans of the nurses' home which is connected to the hospital on two sides. The foundations are designed to carry two more floors when the need arises. Above, left: The clubroom is the center of social activities where students may lounge and enjoy themselves. Above, right: Bedrooms are furnished with double decker beds which can be taken apart and used as singles. Right: The nursing arts laboratory in the basement.

FIRE Costs More Than Prevention

JOSEPH A. P. FLYNN
Supervisor
Bureau of Fire Prevention
State of Maine

BETWEEN 1931 and 1941 there were 46 fires that caused more than $10,000 loss each in hospitals in the United States, with a total loss of $1,439,000. This fire record shows clearly the deficiencies in building construction and the inadequacy of the laws under which many of our buildings were erected. The science of fire protection and building constructions must keep step with the progress of the building industry if we are to take advantage of that progress and reduce the already serious fire loss.

Many will argue that our building costs are already too high and how is it possible to achieve greater fire safety without making such costs much higher? The answer is simple: by more intelligent building regulations, by requirements that reflect the knowledge gained during recent years of the particular hazards and the fire protection to be afforded various types of buildings.

Flame Feeds on Fuel

There is nothing new in the realization that without fuel there can be no fire and that the intensity of a fire is related to the fuel upon which the fire feeds. In recent years, however, valuable data and information have been developed which permit reasonably accurate determination of (1) the degree of fire hazard that exists under predetermined conditions; (2) the average weight of the combustible contents associated with the various occupancies for which buildings are used; (3) the relationship between the weight of combustible content and its potential degree of fire hazard, and (4) the degree of fire resistance provided by various materials and assemblies of materials.

For reasonable safety, the degree of protection specified in each instance should be related to and be adequate for the fire hazard involved. If the protection required is too low, fire safety is sacrificed; if too high, building costs are unduly high, usually without commensurate increase of safety to the public.

The Bureau of Standards has performed burn-out tests in fireproof structures with various concentrations of combustible materials having a calorific value in the range of wood and paper (7000 to 8000 Btu.'s per pound of dry material) and assembled to represent building occupancies. Those tests have shown that the relation between the amount of combustibles present (pounds per square foot of floor area) and the fire severity (expressed in hours of fire exposure according to the A.S.T.M. and A.S.A. standard fire test specifications) is approximately as shown in the accompanying table.

Relation of Amount of Combustibles to Fire Severity

Average Weight of Combustibles, Lbs. per Sq. Ft. of Floor Area	*Fire Severity*	*Average Weight of Combustibles, Lbs. per Sq. Ft. of Floor Area*	*Fire Severity*
5	½ hr.	30	3 hr.
7½	¾	40	4½
10	1	50	6
15	1½	60	7½
20	2		

With reference to the application or use of this tabulation, the Bureau Report BMS-92 states:

"It is considered sufficiently accurate in computing combustible contents to take wood, paper, cotton, wool, silk, straw, grain, sugar and similar organic materials at their actual weights and to take animal and vegetable oils, fats and waxes, petroleum products, asphalt, bitumen, paraffin, pitch, alcohol and naphthalene at twice their actual weights.

A recent survey of three hospital buildings furnishes average combustible contents in pounds per square foot of floor area. (See table on opposite page.)

"When the calorific value of combustibles differs greatly from that of wood or paper or where the combustibles are stored in steel or equivalent incombustible containers, a correspondingly corrected weight should be used in determining expected fire severity from the foregoing table," according to the Bureau Report.

If the average combustible content (weight of combustibles per square foot of floor area) representative of each of the typical common occupancies can be determined, the data presented afford a means of evaluating with reasonable accuracy the degree of fire hazard that exists in these occupancies because of their fuel content. These data also make it possible to express that hazard in terms of the same standard fire exposure used almost universally in modern building codes to express the fire resistance rating of building materials and constructions.

Adapted from a paper presented at the Institute on Hospital Administration, Colby College, Waterville, Maine, June 1946.

Combustible Contents of Hospitals

Hospital Buildings	Average Combustible Contents in Pounds per Square Foot of Floor Area: Movable Property	Exposed Woodwork, Floors*	Total
Rooms (single)	0.8	1.5	2.3
Corridors	0.0	2.6	2.6
Waiting rooms	1.7	1.5	3.2
Janitors' closets and supplies	3.1	3.4	6.5
Doctors' offices	5.7	2.9	8.6
Nurses' offices and rooms	3.1	1.9	5.0
Nurses' infirmary	0.8	2.2	3.0
Diet kitchens and dining rooms	1.2	2.4	3.6
Laundries	4.4	0.6	5.0
Laundries and clothes storage	12.5	0.6	13.1
Dormitories	0.8	2.0	2.8
Pharmacy, dispensary and stores	5.8	1.9	7.7
Lockers, toilets and barber shops	0.2	1.2	1.4
Approximate average for entire usable floor area of three hospital buildings surveyed			5.7**

*Combustible floor finish where present was ¼ inch thick linoleum; it was assumed to be the equivalent of 1 lb. of combustible material, such as wood, per square foot of floor area. Doors, windows, trim, moldings, baseboards are included.

**This approximate average weight was figured from table 16 on page 25 of the Bureau Report BMS-92. The value is somewhat high because the highest weight in each bracket of combustible contents was used in figuring it, *i.e.* in the bracket "0 to 4.9 lbs. per sq. ft.," the value 4.9 lbs. was applied to the indicated area.

Fire is likely to create panic and add to the other hazards associated with it. Panic cannot be eliminated, but the conditions from which it is likely to arise can be avoided. Adequate exits, well placed, suitably marked and, preferably, used for both entrance and exit, will go far toward giving a sense of security that will lessen the panic hazard.

The safety of the occupants is, of course, affected by the fire hazard involved in a building as determined from the combustible content, but their safety also is affected by additional fire hazard characteristics peculiar to each occupancy, not directly related to the combustible content. These characteristics involve the conditions existing within the occupancy that affect the relative ability of the occupants to evacuate the building expeditiously in the event of fire.

These considerations involve such features as whether the occupants are able-bodied or infirm, whether they are of active age or very young or very old, whether they are likely to be asleep or awake during their period of occupancy, whether their liberty is restricted or they have freedom of egress, whether the occupant content is high or low and whether, because of large assemblies or crowds, the danger of panic is added in the event of fire.

These considerations all enter into the proper provision for public safety in the construction of buildings used for the different occupancies and in the interior finish of those buildings. They are of special importance in establishing not only exit facilities but also the limitation to be placed on the use of construction that does not afford fire protection and safety commensurate with the hazard prevailing in the occupancy.

Hot gases from a fire tend to rise. Consequently, differences of temperature created during a fire in a building cause vertical openings and shafts, not properly enclosed and protected, to act as flues, serving to increase the draft on the original blaze and spread the heated gases of combustion, and the fire, to the upper floors with great rapidity.

It is therefore essential that regulations to assure proper fire protection of vertical openings be included in every building code. This can be accomplished by requiring the enclosure of such openings with fire-resistive partition or wall constructions and requiring protection of openings in these enclosure walls. These requirements should be related to the occupancy as well as to the type of building construction.

The degree of hazard involved in the use of combustible finishes is related primarily to the occupancy. It is obvious that use of a highly combustible finish in a building of combustible or non-fire-resistive construction is more hazardous than is its use in a building of fire-resistive construction. Nevertheless, in the occupancies cited, irrespective of the type of construction used in the structure, dangerous fire hazards can be created through the use of interior finishes that are capable of spreading fire rapidly.

PROTECTION

Automatic Sprinklers: Where non-fireproof construction prevails, the most effective way to prevent or to minimize injury and damage by fire is to install automatic sprinklers of the type approved by the National Board of Fire Underwriters.

There has been objection on the part of some hospital authorities to the installation of sprinklers in wards and private rooms. Evidently the premature operation of a sprinkler head, and consequent effect upon the patients, is feared. The probability of such occurrences, however, is remote if the system is properly installed and maintained. Further, if the sprinklers are confined to basements, attics, halls and stair and elevator shafts a large part of their value will be lost, as fires starting in such wards or open rooms can readily gain headway and spread beyond sprinkler control, especially if they reach the interior of non-fire-stopped walls or partitions.

Standpipes: All hospitals, regardless of construction, should be provided with inside standpipes. The number required will depend upon the extent and layout of the hospital building; they should be so located as to serve all parts of the building adequately. For the small building of moderate height in which there is no serious exposure, 2 inch standpipes may be sufficient for first aid requirements; otherwise there should be a larger line, 4 to 6 inches in diameter, equipped for use of both small first aid hose and 2½ inch fire department hose.

Standpipes should extend from basement to roof and be connected to a street main or a suitable pressure or gravity tank; they should have a 1½ inch hose connection and gate valve not over 5 feet above the floor in each story, including cellars, attic and roof. Hose sufficient to reach all parts of the fire section, but preferably not in excess of 75 feet, should be attached to each outlet. The hose should be approved linen, 1½ inches in diameter, and provided with a nozzle having ½ inch outlet.

OCCUPANCY	TYPE OF EXTINGUISHER
Wards	Soda-acid, loaded stream or foam
Halls and corridors	Soda-acid, loaded stream, foam or carbon dioxide
Kitchens	Carbon dioxide, foam, carbon tetrachloride or loaded stream
Laboratories	Foam, carbon dioxide, carbon tetrachloride or loaded stream
X-ray laboratory	Soda-acid or loaded stream, supplemented by carbon dioxide or carbon tetrachloride for electrical hazard
Operating rooms	Foam or loaded stream
Pharmacy	Carbon dioxide, foam or carbon tetrachloride
Miscellaneous basement storage	Soda-acid, loaded stream, foam or carbon dioxide
X-ray film storage	Soda-acid or loaded stream
Combustible anesthetic storage	Foam, carbon dioxide, carbon tetrachloride or loaded stream

Chemical Extinguishers: The extinguisher used should be suitable for the particular kind of fire involved. In general, the various hospital occupancies should be provided with chemical extinguishers as shown in the accompanying table.

Extinguishers should be of a type and make listed by Underwriters' Laboratories. The required number and their distribution should be in accordance with the National Board of Fire Underwriters' standards governing the installation of first aid fire appliances.

It is, of course, highly important that extinguishers be readily available and in proper condition for use when an emergency develops. To this end a reliable man thoroughly acquainted with the mechanism of the various types on hand should be entrusted with their care. Extinguishers should be recharged at regular intervals, the date of each recharge being noted on a tag attached to the extinguisher.

In many instances it has developed that nurses and attendants did not understand how to operate an extinguisher. The responsibility of those in authority should not end with the mere purchase and installation of extinguishers. The nurses and attendants are the very persons who will most likely be called upon to extinguish an incipient fire, hence their training in the use of the various types that may be on hand is a matter of first importance.

Fire Drills: The organization of fire drills is a subject for separate consideration in each hospital; the number and location of exits, the number and character of patients, the location of those in a more or less helpless state, the number of attendants available for removing them and the equipment on hand to facilitate removals must be taken into consideration.

In a well designed fireproof building such drills need not include removing patients to the outside if each story is properly cut off from those above and below and if extensive floor areas are provided with horizontal exit partitions. Neither should the removal of patients be assumed in drills in nonfireproof buildings provided with automatic sprinklers, proper exits and enclosed floor openings. Every hospital should be so constructed and protected as to make it possible and safe for patients to remain within it during a fire. The only patients removed should be those in the ward or area in which the fire is burning and this removal should simply be to another location within the hospital.

Combustible Anesthetics: These, as a rule, include ether, cyclopropane, ethylene and ethyl chloride. Ether is contained in sealed cans usually of ¼ pound size; the others are stored in steel cylinders. It is of the utmost importance that these cylinders, and those containing nitrous oxide and oxygen, be constructed in accordance with the specifications of the Interstate Commerce Commission; they should be so marked. Oxygen and nitrous oxide are both supporters of combustion. For this reason they should not be stored with ether, ethylene and ethyl chloride, which, preferably, should be in a separate room used for no other purpose.

Some hospitals purchase ether in large drums from which the small containers used in the operating room are filled. Such handling of ether may present a serious fire and explosion hazard. It should preferably be done in a small isolated building used for no other purpose. Otherwise, it should be done only in a special room of fireproof construction, having ample window area of thin glass to serve as an explosion vent, a raised door sill, adequate mechanical ventilation, all electrical equipment explosionproof and all equipment grounded to protect against static electricity.

HAZARDS

Up to this point emphasis has been placed on the importance of fireproof construction and the correcting of construction features that contribute directly or indirectly to the fire spread. There are conditions encountered in all hospitals which contribute to the probability of fires. These include means of artificial lighting, heating, fuel and numerous others.

Lighting, Electric and Gas: All wiring should be in conduit. Concealed knob and tube and open cleat wiring have been used extensively in the past and are still the prevailing types found in the old hospitals. The latter types of wiring have given good service and it is possible to make them safe; their weakness, however, is the ease with which they can be tampered with, altered, changed or extended by incompetent persons. Almost all of the wiring defects encountered in hospitals are those arising from improper alterations or extensions made after the wiring system was originally installed and approved.

Under no circumstances should repairs or alterations of gas piping systems be attempted by the hospital mechanics; in every case, leaks or the need of alterations or extensions should be reported to the gas company. A fundamental condition in the use of gas is that all appliances be supplied through rigid piping with proper shut-off valves.

Heating: The panic hazard incident to smoke is always present in even the fireproof hospital and for this reason all heating fixtures should be carefully installed and safeguarded. Many fireproof buildings have combustible interior trim, hence there is the same need for keeping radiators and steam pipes well separated therefrom.

Hot air heating necessitates the use of interior wall and partition ducts with metal grilled wall or floor registers over the openings. In the basement these ducts are connected to metal pipes extending directly to the furnace. In the event of a fire originating within the cellar or basement, the hot air pipes usually collapse, thereby permitting the fire to

find its way into the wall ducts and extend throughout the building. Where such heating systems are installed the hazard should be recognized and minimized in the only possible way, *i.e.* by constructing ducts and all other details in strict accordance with the recommended building code of the National Board of Fire Underwriters.

If the heating plant, *i.e.* boiler or furnace room, is located in any of the buildings containing other occupancies, it should be cut off from all other rooms on the same floor and from the upper story by fire resistive construction, with entrance only from the outside; openings in the walls should be restricted to those necessary for the passage of pipes or ducts.

If anthracite is used for fuel and if the heating plant is properly constructed no hazard worthy of comment is created; on the other hand, if bituminous coal is used there is the possible danger of spontaneous heating with eventual ignition. This rarely develops when not more than a month's supply is kept on hand and when it is stored in low piles with provisions for air circulation at the top and sides of the piles. If a season's supply is stored, it should be kept outside in the open, separated by aisles; the piles thus formed should be maintained at low height.

Many modern plants use oil as fuel. The oil should be stored in an underground tank. A pump system is safest for this purpose. If properly designed and installed, the pump takes suction from an underground tank, the surplus oil finding its way back to the storage tank.

Incinerators: Many hospitals have their own incinerators, which are constructed as an integral part of the building housing them. As the temperatures incident to the reduction of garbage are very high, the wall thickness and insulation of flues, breeching and stack must be thoroughly adequate.

Ventilation: The ventilating system should be installed in such a manner as to prevent the formation of a means for the passage of smoke, heated gases and flame from one story to another in the event of fire.

Kitchens: Ranges, ovens, broilers and similar appliances, unless of a type designed and approved for installation on a combustible floor, should be mounted only on floors of fireproof construction with noncombustible flooring and surface finish or on hearths constructed and supported as required for fireplaces.

Hoods over kitchen ranges and their ducts should be kept at least 18 inches from combustible material or construction, including plaster on combustible base, unless the hood, duct or combustible material is suitably protected. Ducts from range hoods should be independent of and in no way connected with any other ventilating system that is used in the hospital.

Refrigeration: For all types of refrigerants other than carbon dioxide it is preferable to have all pipes and apparatus containing the refrigerant in a separate building; or, if this is impracticable, in a basement room cut off from all other occupancies on the same and upper floors by masonry walls and solid floors and with entrance thereto from the outside only. The refrigerating machinery room should be provided with thoroughly adequate ventilation.

Medical Social Service Relates CAUSE to EFFECT

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THE medical social worker is a necessary and integral part of the hospital team. She has an understanding of human behavior and of social environment, a skill in interviewing and an ability to mobilize the social resources of the community that will increase the effectiveness of medical diagnosis and treatment.

We should not confuse social needs in all instances with economic needs. The medical social caseworker, like the physician, can practice her profession wherever there are ill people, regardless of the organization, the manner of payment or the economic level of the patient. Not all ill people need the services of a medical social worker, but whenever a patient has trouble deciding to have a needed operation or has trouble carrying out a treatment regime or fails to readjust to normal and usual activities (although physically able to do so) after an illness, he may need and benefit from a casework service.

The medical social worker's methods are not unusual or strange; one step might be called "getting a history" or "gathering the facts" or "defining the problem"; another step might be designated as "drawing conclusions" or "making the diagnosis"; another, and usually a later step, might be called "formulating plans" or "instituting treatment."

These steps should not be thought of as occurring necessarily in just that order nor does the process need to cover a long period of time; one interview may be enough. If great change in the individual or marked adjustment of his living arrangements or family relationships is involved, a "case" may go on for a long period of time.

There is increasing evidence that medical treatment without social treatment is often ineffective in the long run, especially in some illnesses or with some patients. Instances in which the social environment or personal emotional problems of the patient appear to have helped cause the illness or are interfering with proper treatment and/or recovery should be referred for "social study." The medical social worker, through

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training in preparation for her profession, has learned how to make such a study and has developed a skill in relating herself to the patient in such a way that she can help him, at the same time increasing his self understanding and assurance so that he becomes increasingly able to help himself. The medical social caseworker is also best prepared to help patients select and make appropriate use of other community resources.

It is important to remember that only qualified personnel should be employed to perform these services. Present standards call for a preparation consisting of two years' graduate work beyond the A.B. degree in a recognized school of social work, with specialization in medical social casework in the second graduate year.

The well meaning, interested person who wants to help people is no better prepared to be a caseworker than the housewife who prepares three well balanced meals every day is prepared to be a dietitian or the person who likes to care for the sick is prepared to be a nurse.

The subject of the contribution of medical social service to tomorrow's hospital would be incomplete without discussion of some of the administrative jobs often assigned to the medical social service department. The first to be considered, in view of the size and apparent importance of the job in the public hospital or the voluntary hospital taking free or part pay patients, is the problem of admission or financial eligibility of patients for medical services. This assignment presents a number of problems and the appropriateness of the assignment is determined by the solution of these problems.

In my opinion the responsibility for admissions is not an inappropriate assignment *per se;* by that I do not mean that the actual admitting interview is a task to be assigned to a medical social caseworker. Scarcity of qualified staff leads to the necessity of deciding carefully about such assignments. The basis on which family and child service agencies or relief organizations often assign their best workers to "intake" does not provide analogous reasons in the medical setting.

In the field of health, the private practitioner provides a steering service in the community that is not available in the family service or relief field. The family may need help in deciding what service or financial assistance it needs or can make use of, but the need for medical care is a fact that can readily be determined by a physician and the family's financial ability to pay for such care is a straightforward problem in arithmetic, *i.e.* allowing for ordinary needs of the immediate family or responsible relatives, is there sufficient money to pay for needed medical care at current private rates?

Muhlenberg Hospital, Plainfield, N. J. Photograph by William Rittase.

The social service department aids in their treatment, too.

To consider an application for part pay or public medical care in the same light as an application for assistance in the provision of food or rent is not consistent with the fact that the majority of families in the United States today are unable to pay for private medical care at private rates or are receiving less than adequate care.

Another fundamental difference in the application process is that in the application for material assistance every attempt is made to encourage the maintenance of self support and postponement of acceptance of relief, whereas in medical care, obtaining care as early as possible in the illness is desirable and is an economy in the long run. If the patient is a veteran, merchant seaman or member of a group medical plan, medical care may be available as his right. The amount and kind of judgment possible or needed in the admission process should, in my opinion, determine whether it is necessary or economical to use trained professional staff in the admitting process.

At Los Angeles County General Hospital where rules of admission and rates are set by law and ordinance and where bills are rendered in most cases for the cost of the care, we find that, with some exceptions, admission interviews can be adequately done by admission workers, a subprofessional group trained in interviewing and taught the laws, policies and procedures of the department under the supervision of medical social work staff, with a few medical social caseworkers in the same section to take over cases that present social rather than eligibility problems. The admission worker in our hospital is also responsible for referring ineligible patients elsewhere for care.

If the number of applicants is not large enough to allow for this differentiation, it is appropriate, I believe, for the caseworker to perform admission work in addition to casework services. Since admission or eligibility is an administrative problem, it may be affected by changes in administrative setup and espe-

cially by changes in legal definition or policy as to what group the hospital is required to or is willing to serve.

Other duties have in the past and may in the future be assigned to the medical social service department, some appropriate and some not. Each administrative assignment already carried or suggested for the future should be scrutinized with the idea of taking on only those tasks which not only are best provided by social service but, more important, really belong there because they are closely related to its core of practice.

It is an especially dangerous pitfall to accept all assignments which are in any way "social" in nature. If proper attitudes prevail and if adequate services to the patient are being carried on, the administrator, physician, nurse and dietitian are concerning themselves constantly with some aspect or other of social problems.

The hospital itself is a community or social institution. The social caseworker is the only one, however, who by special knowledge and equipment should engage in what, for lack of a better term, is called "social treatment."

The inappropriateness of many jobs can easily be recognized by realizing that they would be done better if done by some other profession or that they are inextricably related to the work of another department.

Much has been written on the proper organization of medical social service departments. The statement on standards is as follows:

"1. Medical social service should be an integral part of the institution.

"2. The executive head should be responsible to the executive officer of the institution.

"3. The head of social service should be a member of conferences called by the executive officer to participate in any plans or policies pertaining to social care of patients. . . ."

With the extension of medical social service outside the hospital, these standards cannot be applied literally, but the principles they set forth can be translated into terms that are applicable to the new setting. The organization of which I am a part has a bureau of medical social service, with a staff serving in three major medical institutions and 10 medical aid districts.

There is not an absolute administrative responsibility to the heads of the separate institutions, but the director of the bureau of medical social service is responsible to the superintendent of charities, as are the administrators of the various institutions.

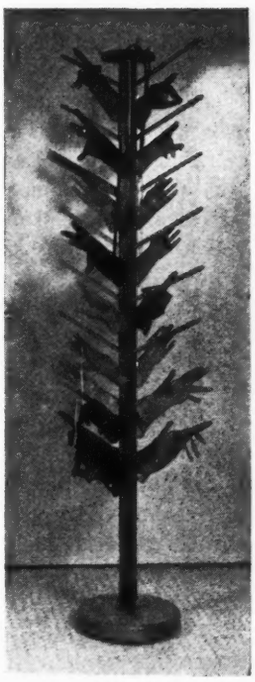
In the plans suggested by the U. S. Public Health Service for future organization of community health services, encompassing health centers, rural and district hospitals, institutions for chronic care and base or central hospitals, our experience in Los Angeles County may be helpful in planning the organization of medical social service to serve in such a community plan.

Medical social service can, in such an organization, make a valuable extra contribution in helping in the coordination of care by direct help to the patient and by influencing procedure so that a feeling of continuous care is a reality for the patient.

Tomorrow's hospital, if it is interested in obtaining the services of medical social caseworkers, will need to become concerned about where such persons are to be found and at what price. The American Red Cross, the Veterans Administration and various national health agencies, *e.g.* National Tuberculosis Association and National Foundation for Infantile Paralysis, have faced this problem and are entering into fairly extensive and liberal scholarships or work-study plans. The Children's Bureau, Crippled Children's Services, has for some time been continuing the salary of persons on the staff who return to school for additional training.

Hospitals, either separately or jointly, should give thought to making some contribution to the training of the staff or at least be willing to pay salaries equal to those paid to qualified professional persons in related fields. Eventually, it is hoped that we shall be able to attract more qualified persons to the profession. Expansion of services in the face of scarcity of qualified personnel is impossible.

It's a Glove Drying Rack



A SIMPLE wooden glove drying rack was built at the Veterans Administration Center at Fargo, N. D. It has a 2 by 2 inch center post, 62 inches high with a 6 inch central headpiece and 12 inch circular heavy base. In the center post are dowels 10 inches long, spaced 6 inches apart at staggered intervals from the headpiece to 15 inches from the base. Three small pieces, 1½ inches long, extend from the circular headpiece and are used to dry intravenous tubing.

The center post rotates on the base by means of a caster bearing taken from a discarded bed. A clutch bearing may be substituted to prevent wabbling of the center post. A red line may be drawn at any point to indicate the separation of torn or punctured gloves from undamaged ones.

The rack is time saving, permits rapid drying since the glove opening fits on the smooth peg, provides a double check for damaged gloves and permits segregation of damaged gloves at time of drying. It saves space because it is compact; it is readily movable to any unoccupied corner of the surgical theater.—Capt. J. L. Diamond, M.C.

Reprinted from the Bulletin of the U. S. Army Medical Department.

The Modern Mental Hospital Must Be

Planned Around the Patient

and integrated with the community

STANLEY STELLAR, M.D.
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IT WOULD be a mistake of the first magnitude to plan tomorrow's improved and rejuvenated psychiatric hospital from the point of view of anyone but the patient. Psychiatrist, psychologist, professional administrator, special therapist, social worker, nurse and attendant are all hampered by necessarily restricted fields of vision. Since the health of the patient is the goal and his needs, therefore, are primary, the broadest and wisest approach is through him. Yet it would be a fictitious patient indeed who could contribute to psychiatric planning.

Perhaps, however, we can imagine a psychopathologic monstrosity suffering from all the mental ills to which mankind is heir and at the same time endowed with the knowledge and talents of all who will participate in his treatment. What would such a richly endowed but unfortunate person require and want for the preservation and restoration of his mental health?

Close Affiliation Required

In general terms, bettered intramural care of psychiatric patients must be carried on in an institution which is an integral part of the community. I believe it is a matter of indifference whether patients are cared for in psychiatric divisions of general hospitals or in separate establishments. It is imperative, however, that the closest possible affiliation be maintained with the rest of medicine and surgery, as well as the specialties. In addition, the hospital should be large in order to reap the benefits of cooperation among varied departments.

For unfailing service to the purpose—and the purpose can be none other than the psychobiological-social health of the people—flexibility and adaptability must be outstanding characteristics of the institution. While allowing for the continued employment of methods of known benefit there must, nevertheless, be a willingness to adopt new procedures, fresh attitudes and useful hypotheses as these prove themselves of value.

Teaching, research and experimentation can create a university atmosphere that will redound to the patient's immediate and future welfare. The leading principle for such a hospital is, of necessity, continuously rising standards in all departments and the spirit and atmosphere of the institution will mean the difference between mediocrity and superiority.

The life of an institution is one with the members of its personnel. It is they who direct its activities and produce its results. The hospital as a social organism can never excel the quality of its members. If, therefore, superior psychiatric care is to emanate from it, only men and women of undoubted ability in their fields can be employed. Insofar as is humanly possible selection should operate to retain those who are intelligent, alert, sincere and altruistic, enthusiastic, interested, even fascinated by their work.

University affiliation should be established wherever possible and staff members of the hospital ought, likewise, to be faculty members of the university. Geographical propinquity of the two institutions will facilitate their cooperation and enhance the benefits each can afford to the other.

When university connection is not possible, hospital personnel can and must create a university within the walls of the institution by maintaining programs of continuous research, teaching and training. These programs will combat the well known tendency of all human beings to become set in their ways, fixed, rigid, less open to new ideas and methods. Institutions reflect this tendency but broad visioned, progressive, active personnel can prevent such a misfortune.

Despite a necessarily close connection between hospital and community, detrimental political restriction or control of staff members and policies cannot be tolerated. A benign and enlightened administration can, on the other hand, be of great help in preserving orientation on the part of the institution to the changing needs of the community.

Remuneration Must Be Adequate

It is to be expected that the administration will see in the welfare of its employes direct benefits to patient and society. Quantity of personnel and its distribution among the various categories should be such as to allow each individual to give his optimal performance. Remuneration in all departments should be adequate to attract and hold superior persons while at the same time freeing them from personal economic problems that impair their efficiency and prevent a proper therapeutic relationship to the patient.

It is understood that the modern psychiatric hospital will have on its staff all the types of personnel at present known to have something of value for the mental patient and that room will be made for additional specialists as new procedures are adopted by the profession.

While it is necessary for the house staff to live within the confines of the hospital, it will certainly be better for most others to make their homes in the outside community. This will avoid narrowing of outlook and harmful institutionalization of personnel.

FIVE POINTS IN PSYCHIATRIC PLANNING

1—Care of Patients

2—Research

3—Teaching

4—Program of Mental Hygiene

5—Program to Combat Behavior Disorders, Delinquency, Crime

The physical nature of the hospital plant should be such as to foster the aims and programs of its personnel. It must provide adequate facilities for housing patients and personnel, for teaching, study and research and for all forms of diagnosis and therapy. Yet I do not doubt that more than one design would serve admirably.

More important than the fixed form will be the possibility of change when it is evident that change is due. It should not be necessary for the old buildings to crumble before new ones are erected. As the character of hospital care of psychiatric patients alters with the years, modifications, additions and deletions should be made in the structures housing the institution. When it is obvious that the old facilities have begun to outlive their usefulness they should be abandoned. Obviously, this presupposes an educated and wisely spending community.

Size and Location Vary

The exact size and location of the hospital need not be discussed here since these will vary with the needs of the community and local circumstances. The modern hospital, like the traditional one, may well be planted within an existing community but there are advantages to be gained by having some hospitals, at least, form the nucleus for living, breathing communities of their own. Such a hospital would be set up on unbroken ground away from any previous human settlement—but not by any means far away. Here would live only patients and hospital personnel and all property and buildings would be for their sole use.

The hospital itself, with its floors of patients under active medical psychiatric treatment, would form the core. Emanating from it, to make up the community, would be dwellings, farms, industrial plants, small businesses, places of amusement and recreation, schools, parks, transportation and communication facilities and other public utilities, in short, everything that comprises a small, modern living social unit of and by the patients.

Suitable patients would be treated there on a social plane and there they would be tested under conditions simulating as closely as possible the family and community life to follow. Everywhere would be hospital employes contributing their specific abilities to guide and help, to supervise methods and judge progress. Knowledge and skill would be gained in the deliberate manipulation of the various environmental factors for diagnostic, therapeutic and prognostic purposes.

Desensitization, conditioning and attitude formation could be attempted not only on an individual but on a social level and not for evil but for good. This had better be no ideal and protected community but one resembling the home environments of the patients themselves and changing with them.

In the last analysis the value of any institution to the people of the community it serves is dependent not upon the personnel or buildings which comprise it but upon the things it does. A modern psychiatric hospital should be the concrete expression of a continuous process, the process of betterment of the mental health of the people.

The achievement of this end calls for the establishment of definite programs. The programs will of necessity overlap and although those listed below seem to be natural subdivisions, other breakdowns are undoubtedly possible. Five main groups of activities are proposed, as follows: (1) professional care of patients; (2) research; (3) teaching; (4) program of mental hygiene, and (5) program to combat behavior disorders, delinquency and crime.

There should be a readiness to make additions as changing conditions demand them. The programs will be discussed separately and in the order presented.

Care of Patients. The only sensible rule to follow is one which says that any method that helps the patient is eligible for consideration and utilization. All schools of thought, all methods of study, all modes of treatment should be given place proportional to their worth. It is unnecessary to list the specific diagnostic and therapeutic procedures in common use today. However, in addition to the traditional inpatient and outpatient services, the modern hospital will be unable to avoid including a program of rehabilitation that will follow the patient all the way from hospital to full-fledged, economically independent family and community life.

Change Patient's Status

The chief function of the rehabilitation program will be to implement and facilitate the change from patient status to mentally and emotionally healthy citizen. Nor can the program be relaxed with the attainment of this goal. On the contrary, it must continue to operate so as to maintain its first achievement, even to improve upon it. Here it will merge with the program of mental hygiene.

Research. Like its fellow, teaching, research may be considered to be congealed treatment for future patients. A really active program will include any research made possible by the talents and abilities of the hospital personnel, the clinical ma-

terial available and the physical facilities and financial resources at hand.

Undoubtedly, the hospital of the future will coordinate its research with that of other institutions under a state or national program. This will avoid useless waste and duplication, speed up and give more certainty to evaluation of the results of new procedures and result in the guidance of research projects toward more urgently needed and more immediately useful goals.

Initiative Is Not Stifled

Enlightened coordination of research, properly administered, need never stifle individual initiative and originality or abolish so-called pure research—studies possessing value not presently apparent. The hospital's researches should not be tucked away out of sight of the majority of the staff but rather belong to all and should be shared by all. The stimulating effects of research and the immediate benefits to the patient are too well known to require further comment.

Teaching. Teaching will give life and continuity to the hospital's activities. University affiliation will result almost automatically in teaching but efforts should be made to develop programs including all personnel. The presence of medical students, students of occupational therapy, psychologists working for their degrees, student nurses belonging to the hospital itself or to general hospitals desiring affiliation and student psychiatric social workers will constantly refresh and renew the institution and its staff.

In return, great service can be rendered continuously to a widening circle in the community as graduates leave and become dispersed to other institutions. Formal and informal courses, as well as apprenticeships, should be established and instruction and training should extend from attendants right up to the postgraduate level.

Doctors practicing in communities served by the hospital will benefit by instruction designed to make them more aware of and conversant with psychiatric problems. It is these doctors who will often be in a position to detect incipient mental disorder and, when possible, to institute preventive measures at the earliest moment. It is they, also, who will have the closest relation to and the greatest influence upon families of patients or potential patients.

Perhaps even more important than the prescribed forms of instruction is a spirit of teaching that can permeate a whole institution and infect every member of it. Daily contacts among different staff members on rounds, at the bedside, in clinic and laboratory will serve admirably for teaching situations. Data and clinical material will be found in abundance. There and in lecture hall, seminar room, conference room and library the fruits of experience can be passed from one to another.

To avoid the narrowing influence of education and practice in a single institution, permanent staff members should be encouraged, urged and helped to study at other hospitals. Relationships should be maintained not only with similar institutions but with those that treat different types of patients and carry on different programs. The staff members would then return refreshed and renewed, full of vigorous new ideas and hopes.

Books, journals and other writings in medicine, psychiatry and related fields should be abundant and accessible while writing and publication of worthwhile material should be fostered and encouraged.

Program of Mental Hygiene. Mental hygiene properly begins at home. A small scale program should be carried out within the hospital for the benefit of its own personnel. Outpatient as well as inpatient treatment for existing disorders will, of course, be available to all and to the extent possible it should be inconspicuous and considerate of the patient's privacy.

Adequate pay, good, attractively prepared and well served food, proper living facilities and a genuine interest on the part of the administration in the welfare of the employe are basic to the creation of good morale, pride in the hospital and an unmistakable desire to work and be of value to the patient. Truthful but judicious reporting of the hospital's achievements and attention to emphasizing the part played by each in attaining those achievements will weld the institution into a harmonious, smoothly functioning, purposed social unit.

Above all, the individual cog in a large family wants to know that he is receiving the best treatment possible under existing circumstances. The fullest possible participation in matters related to his own welfare not only will benefit the employe but will also accrue to the patient in the form of better personal treatment.

A much larger program of mental hygiene is owed to the people of its community by the progressive psychiatric hospital. This program will benefit by close affiliation with existing national programs and, while special arrangements must be made to meet local conditions, the hospital program should be an integral part of the larger plan. A dovetailing with general public health measures is also advisable for it will unify efforts along these lines and serve to keep a proper relationship between mental health and general health.

Existing mediums of communication and education should be utilized to the greatest extent possible. Education of the public begins in the earliest school years and it will be wise to establish a close connection between hospital and school system. Parents can be reached individually or through the various associations to which they belong.

Lectures, exhibits, movies, the radio, newspapers, books and other publications can all be of use in a plan to educate the public and remove forever the fear and stigma of psychiatric disorders. The hospital may well have its own child guidance clinic or be closely associated with those already functioning.

Setup for Outpatient Service

There is a growing need for some kind of outpatient consultation service designed to handle the problems of persons who fall between the normal, on the one hand, and the definitely, though mildly sick, on the other hand, who ordinarily seek professional advice privately or in outpatient departments. This service might well function during evenings only and its location would best be away from the hospital, preferably in an ordinary business office.

The name given to it ought to be free of conspicuous psychiatric or medical connotation. A name such as "Personal Adjustment Consultation Service" would be suitable. The service would manage only the very early, incipient, borderline maladjustments occurring chiefly as the result of unusual environmental factors and not requiring prolonged or complicated treatment.

Cases should be such as could be disposed of with a few words of advice in one or possibly a few interviews. Expert guidance in special fields, other than referral to proper agencies or sources, need not be undertaken. Records should be kept to the minimum. The consultation service would refer its more serious psychiatric problems to the regular outpatient department of the hospital.

Cases referred to the service could come from parents, teachers and other group leaders or they could be considered at the request of the person involved without recourse to an intermediary. A consultation service such as the one described would undoubtedly be of great value to the community and be a potent force in the preservation of mental health.

The entire mental hygiene program must be both preventive and constructive. Whenever causes of maladjustment are discovered, which are largely beyond the control of the individual but remediable by group action on the community level, recommendations for the removal of such causes should be made to the appropriate governmental authorities.

An obvious example is widespread unemployment resulting from economic or other factors. Another example might be insufficient or poor education in certain definite spheres, such as the sexual. In matters like these close liaison between the hospital and its community would bear fruit.

Program to Combat Behavior Disorders, Delinquency and Crime. Behavior disorders, delinquency and, to a lesser extent, actual serious crime have come within the purview of psychiatry for a long time. Much splendid work has been done but psychiatry on the whole has not been able to offer its full resources and potentialities for the eradication of these problems. The primary need at present is for research into the causes and management of aberrations from accepted mores and laws.

While studies on hereditary factors should continue, greater emphasis must be placed upon environmental determinants. The basic needs inherent in animal flesh form the matrix out of which crime is born but social and economic forces, ethnographic and cultural factors and emotional, largely unconscious, patterns produced by family and other personal relationships furnish its form and direction. When the roots of delinquency and crime are exposed, then only can they be intelligently influenced for the betterment of mankind.

Along with these studies must go dissemination of information to the agencies involved in crime prevention and to the people themselves through schools and parents. Useful, practical advice must be furnished to the governmental departments employed in the fight against crime. A guide must be created for bold experimental procedures designed to make crime impossible. An even closer link-up than has hitherto been established between psychiatry, on the one hand, and penology and criminology, on the other, must be forged.

In the formation of these new attitudes and the carrying out of enlightened procedures to reduce crime to the minimum the modern psychiatric hospital can play a large rôle. Each of its other programs, the care of patients, research, teaching and mental hygiene, has much to offer.

An important basic need is to produce persons with training and qualifications that fit them for directing or participating in this program. At the present time our medical and law schools certainly do not fulfill this need. Nor do they provide the average student with the fundamentals in any planned way. Not only will undergraduate attention have to be devoted to these problems but also, more important, postgraduate training will need to be provided and then progressively expanded. The need exists. It is for us to meet it.

The programs described need not be construed in such fashion as to exclude other activities not specifically mentioned. They should, on the contrary, be continuously modified to embrace worthwhile projects as the value of these becomes clear. Considered together, the programs form a basis for an actively functioning, immediately useful, modern psychiatric hospital. Such an institution would rightly be a source of pride on the part not only of its staff but also of its patients and the community at large.

It must not be thought that plans for a modern psychiatric hospital, like these presented, are considered oracular merely because they have assumed written form. On the contrary, they fall by design far short of completeness and omit many of the details which must be arranged before the plans can be translated into concrete reality. They are by no means intended to be a blueprint or even a durable model. Rather are they the verbalization of thoughts that must have occurred to many other people as well.

There can be no final achievement. Instead there must be only progress, both gradual and in spurts, and the various stages of development in psychiatric hospitals will best be based on the most worthy ideas of many different people.

ADMINISTRATIVE CAPSULES

• You never saw a doctor turn away a paying "chronic" patient from his office.

• The graduate nurse (R.N.) is the aristocrat of the nursing profession. All the more reason for expecting her to show nobility of character in dealing with her newly arrived younger sister, the practical nurse.

• Without disrespect to the medical profession, every death should be considered a clinical failure—and the same may be said for complications, sequelae, chronicity, relapses, social dependence and, in fact, illness itself. Failure in these cases means failure in prevention.

E. M. Bluestone, M.D.

ABOUT PEOPLE

Administrators

David R. Kenerson has been named to succeed **Frank B. Gail** as administrator of West Jersey Hospital, Camden, N. J. Since March 1945 Mr. Kenerson has headed King's Daughters' Hospital at Portsmouth, Va. He was administrator of Clearfield Hospital, Clearfield, Pa., for two years prior to that.

C. E. Johnson, resident auditor of Fairmont General Hospital, Fairmont, W. Va., recently assumed the duties of acting administrator of the institution following the resignation of **Charles E. Vadakin.**

Thomas H. Head, assistant superintendent and business manager of Shannon West Texas Memorial Hospital, San Angelo, Tex., was unanimously chosen president elect of the Texas Hospital Association by the board of trustees to fill the vacancy created by the resignation of **Russell C. Nye.**

Clifford E. Hunt has resigned from the position of administrator of Lubbock Memorial Hospital, Lubbock, Tex., which he has filled for twenty-seven years. Mr. Hunt became head of the hospital in 1919, a year after it was opened. He has been active in hospital work throughout Texas and assisted in the organization of the Northwest Texas Hospital Association in 1929. He is a past president of that organization, as well as of the Texas Hospital Association. His resignation from the hospital was necessitated by ill health.

Dr. Clayton Potts of Walla Walla, Wash., one of the few American doctors with a license to practice in Peru, was scheduled to sail from New Orleans on September 1 to establish a new Seventh Day Adventist Hospital at Chacclokayo, Peru, a suburb of Lima. For six years before the war, Dr. Potts served as a missionary near Lake Titicaca.

Thomas K. Leinbach was the choice of the board of trustees of Community General Hospital, Reading, Pa., as administrator of the institution. **Alice B. Hangen,** who has been acting superintendent since the resignation of **Olin L. Evans** last fall, will remain as assistant superintendent. Prior to accepting the post as head of the hospital, Mr. Leinbach had been personnel director for Vanity Fair Silk Mills, Inc., which he also served as advertising manager and plant manager. A native of Reading, the new superintendent has been active in civic and fraternal organizations in the town.

Mrs. Nelle Mae Lowe is to be the administrator of the new Johnson County Hospital at Franklin, Ind.

Wilson W. Lowrance has been appointed superintendent of the Tuomey Hospital, Sumter, S. C., succeeding **John W. Rankin** who is assuming the directorship of James Walker Memorial Hospital, Wilmington, N. C. Mr. Lowrance was superintendent of the Cherokee County Hospital, Gaffney, S. C., prior to his service in the army. Following his discharge as a major he was appointed director of the hospital survey for the North Carolina Medical Care Commission.

R. Arthur Carvolth has been appointed superintendent of Caledonian Hospital, Brooklyn, N. Y. Prior to his army service as receiving and evacuation officer of the 227th General Hospital in France with the rank of major, Mr. Carvolth was superintendent of the Potsdam Hospital, Potsdam, N. Y. He succeeds **Nora Young** who is retiring after many years of service.

John Latcham is the newly appointed assistant director of Rhode Island Hospital at Providence, **Oliver G. Pratt,** executive director, announces. Mr. Latcham, a graduate of the University of Colorado, served three years as an M.A.C. officer with the University of Colorado unit, the 29th General Hospital, in the South Pacific and in Korea.

At the same time announcement was made of the appointment of **James Duncan MacDonald** as controller of Rhode Island Hospital. Mr. MacDonald is a certified public accountant of Rhode Island and has had experience with accounting firms in Providence. He served three years in the navy as assistant supervisory cost inspector for the 13th Naval District.

William Vaughn Herrin has returned to his home town of Hastings, Neb., after three years in the army to assume the duties of superintendent of Mary Lanning Memorial Hospital. He succeeds **Augusta Christianson, R.N.,** superintendent since 1941, who resigned to accept the position of anesthetist at St. Luke's Hospital, Denver.

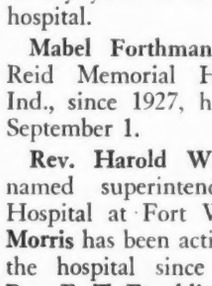
Donald W. Duncan, credit and assistant business manager of Creighton Memorial, St. Joseph's Hospital, Omaha, Neb., since 1941, on September 1 assumed new duties as business manager of St. Elizabeth's Hospital, Lincoln. Mr. Duncan is president-elect of the Omaha Hospital and is also secretary-treasurer of Nebraska Hospital Assembly.

Mrs. Gertrude Scott has resigned as superintendent of Ortonville Hospital at Ortonville, Minn.

Mrs. Marie Linder has resigned as administrator of Daviess County Hospital, Washington, Ind., to assume a similar position at Fairview Hospital, La Porte, Ind., where she succeeds **V. I. Sandt** who is retiring after nearly twenty years of service as head of the hospital.

Mabel Forthman, superintendent of Reid Memorial Hospital, Richmond, Ind., since 1927, has resigned effective September 1.

Rev. Harold W. Mohler has been named superintendent of Methodist Hospital at Fort Wayne, Ind. **Lucille Morris** has been acting superintendent of the hospital since the resignation of **Rev. E. T. Franklin.**



Dr. Joseph Scattergood Jr., director of Darlington Sanitarium, has been appointed director of Chester County Hospital, West Chester, Pa., succeeding the late **Alton F. Reichgert.** Dr. Scattergood interned at the hospital in 1929-30 and was appointed head of the physical therapy department in 1932, a post which he held until his appointment as director of the hospital.

Robert T. Besserer is now assistant to the administrator of Orange General Hospital, Orlando, Fla. Mr. Besserer served in the army for five years and prior to that was engaged in hotel work.

Dr. H. H. Brueckner has resigned as superintendent of the District Tuberculosis Hospital at Lima, Ohio, to become head of Molly Stark Sanatorium, Canton, Ohio. He will be succeeded at Lima by **Dr. Ernest Holsted,** formerly of the Pleasant View Sanatorium, Amherst, Ohio.

John F. Barker has accepted the appointment as administrator of Valley View Hospital, Ada, Okla.

Dr. Francis H. Sleeper is the new superintendent of Augusta State Hospital, Augusta, Maine, and consultant on

(*Continued on Page* 160)

LESSONS in LABOR RELATIONS

ARTHUR C. BACHMEYER, M.D.
NELLIE GORGAS
ALDEN B. MILLS

THE majority of employers in the United States are still opposed to collective bargaining through trade unions. In Great Britain, on the other hand, the majority of employers take trade union collective bargaining as a matter of course. But that attitude is the product of a long period of evolution. During the greater part of the first three quarters of the nineteenth century, British employers fought the principle of trade union bargaining as bitterly as many American employers do now, but the growing power of labor organizations finally forced the employers to deal with the unions.

No doubt, many British employers would be glad to free themselves from the limitations imposed upon them by these agreements, but unions are too firmly entrenched in the British social order. In the same manner, American employers who now recognize and deal with unions do so not because they prefer this system but merely because there is no practical alternative.

Unions Are Part of Industry

From a careful review of the development of collective bargaining, it is evident that the increased growth and influence of trade unions in all modern industrial countries indicate that they are tending to become a part of the modern industrial order. A growing number of employers recognizes collective bargaining as necessary in modern industry.

William Howard Taft, former president and later chief justice of the Supreme Court of the United States, gave his opinion as follows:

"Organization of labor has become a recognized institution in all the civilized countries of the world. It has come to stay; it is full of usefulness and is necessary to the laborer.

"There is among employers . . . the man who never learns anything and never forgets anything; the man who says, 'It is my legal right to manage my business as I choose, to agree to such terms of employment as I choose, to exclude from my employment union men, because I don't approve of the tenets of the union, and to maintain a family arrangement of my own. I do fairly by my men; I pay them what I think is right and they will not complain unless some outside agent interferes. I run a closed, nonunion shop and I am happy and I propose to continue happy.' . . .

"This man is far behind in the progress of our social civilization. He lacks breadth of vision extending beyond the confines of his shop. . . . He does not recognize that we have advanced beyond the state in which employers and employes are mere laws unto themselves. . . . But whether we will or not, the group system is here to stay and every statesman and every man interested in public affairs must recognize that it has to be dealt with as a condition, to be favored in such a way as to minimize its abuses and to increase its utility."

A further indication of the possible future of collective bargaining in the United States may be obtained from data provided by Leo Wolman, professor of labor problems of Columbia University, who gave an address at an institute on hospital personnel relations last year.

Total active, dues paying membership in all unions in the United States he estimated at the following figures: 1914, 2,700,000; 1920, 5,000,000; 1923, 3,500,000; 1929, 3,400,000; 1933, less than 3,000,000; 1939, 7,900,000, and 1943, 11,300,000.

Mr. Wolman stated that these figures are considerably lower than the memberships usually claimed by the unions but that he considered his figures actual "net" membership. By categories of employment, he stated that the percentage of workers who are now organized runs as follows: mining, 85 per cent; construction, 70 per cent; transportation and public utilities, 50 per cent; factories, 33 per cent; government, 10 per cent, and trades and services, 8 per cent.

Situation in San Francisco

In the hospital field there has not thus far been a great deal of unionism of any type. San Francisco, however, provides an example of a development which may spread in the future. According to William G. Storie, vice president of the San Francisco Employers Council, "prior to 1937, the hospitals in San Francisco carried on relationships with the union directly without industry-wide collective bargaining agreements. Several individual agreements were made in 1937, but it was not until April 15, 1941, that an industry-wide agreement was made between the employers and the Hospital and Institutional Workers Union."

This was a two year contract with the provision that the agreement might be reopened after one year for reconsideration of wage rates only if the cost of living index for San Francisco, as published by the U. S. Bureau of Labor Statistics, had increased 10 per cent or more above, or decreased ten per cent or more below, the figure published for the nearest date preceding the signing of the contract.

This is the concluding article in a series of three on personnel practices.

The matter could not be settled by mutual agreement when the union asked for reconsideration of the wage scale a year after the agreement had gone into effect and it was finally taken to the National War Labor Board for decision, the first such case to be referred.

The directive from the board included a $20 per month wage increase on the basis of increases in the cost of living; substandard wages in the hospital field as a whole compared to salaries for similiar work in other types of employment and in some other hospitals in the area, and the view that hospitals were able to pay this increase because it could be met by an increase of 50 cents per patient day, which their clientele might well meet.

Cast Doubt on Immunity

The late Dr. Benjamin W. Black, in his presidential address to the American Hospital Association in 1941, summarized the situation at that time effectively by stating that when labor anti-injunction acts became laws in 25 states to hamper the granting of injunctions against strikes, hospitals had assumed that they were not concerned, inasmuch as they were not industries in the ordinary sense of the term, but that recent court decisions had cast considerable doubt on that assumption.

In spite of the fact that three states and the Supreme Court of the United States all ruled that it would, in their opinion, be impossible to operate hospitals properly "should we hold the Labor Act applicable with all its attending ramifications, interruptions and possible cessation of service due to labor disputes and attending financial inability to function," and stated that "largely the legislature had no such intention and we cannot so find, in the absence of a clear and positive declaration to that effect," Dr. Black felt that there were dangerous implications in these decisions. Other states might soon rule differently when their turn came.

He pointed out: "It has been well said that in every religion held sacred by man the care of the sick is held to be a spiritual task and he whose influence and behavior interfere with such time honored traditions and customs must assume a responsibility not usually undertaken for trifling reasons." This expresses the primary factor which has heretofore retarded the development of union activity within hospitals.

Another factor, of course, was that it was hardly worth while financially for craft unions to organize hospital employes since so few in each craft were employed in any one hospital. With industrial unions, the situation is different.

The unionism that has developed in hospitals has usually been through national trade unions, where workers in similar positions in industry or government service have attempted to strengthen their own organizations by admission of additional members who are hospital employes. In Minneapolis, for instance, the Public Service Building Employes, Local No. 113, of the American Federation of Labor, has been the group to absorb the hospital employes. In Wisconsin, the State, County and Municipal Workers' Union, C.I.O., has enrolled some employes of government hospitals.

The hospital has problems which are unique and concern, for the most part, only the employes and the employer of that one type of institution. Its employes, as a rule, except for the maintenance group, which belongs often to the same trade group found in other organizations and institutions, neither interest any outside labor group nor provide workers interested in the problems of the other groups.

Approach Maintenance Groups

When trade unions must gather every bit of strength possible, they approach the hospital maintenance groups first, but even the professional groups may be approached occasionally. At the present time in which there is considerable labor trouble such approaches are being made in various places.

It should be emphasized that, in many hospitals, the question of collective bargaining may never arise. The following discussion is presented only as informative so that those concerned may be aware of what has happened heretofore and perhaps have some understanding in case the problem should arise for them.

Who Shall Represent the Hospital in Collective Bargaining? As hospitals realize that business efficiency is essential even in a service organization, they pay more and more attention to the personnel problem, the employe-employer relationship, and adopt the best procedures found in industry.

Many of the larger hospitals have appointed personnel officers who spend either full time or part time on the problems of the employes and advise or act on all questions involving relations with hospital workers. In other cases, an assistant administrator or some member of the administrative staff has been assigned the task of working out the details of the personnel relations program.

It may become necessary to deal with employes as a group more and more frequently, regardless of whether they are formally or informally organized. Frequently, the negotiations are by joint conferences between three or four representatives of the group and the administrator.

Trustee Should Be Included

If the matter is of large importance, one or more of the trustees should be included because they will give full weight to the administrator's requests and complaints. If there is a personnel officer, he should be included, of course, in all such conferences. A committee including the administrator, the personnel officer and a representative of the board is best if a vital question must be considered.

A small committee should be appointed; otherwise, it is too difficult to achieve unanimity of opinion and action. The spokesman for the hospital should be the one best qualified in the handling of people. He must be a person whose every act and word are known to be fair and reasonable. If the matter concerns several hospitals, it would be well to have it attended to by a special committee of the hospital council on which both administrators and boards of trustees are represented.

What Should Be the Attitude of the Hospital Administrator? In settling any controversies, the general public must be considered and also the economic conditions of the times. For instance, when salaries are skyrocketing, the administrator must be willing to talk and deal with his employes on the matter of changing salary schedules.

The public and the courts are sympathetic with the hospital stand that there can be no cessation of service in the hospital, but they are swinging more and more to the position that there is no reason why

working conditions cannot be made comparable to those in similar positions outside the hospital field.

As to the particularly important point of the economic conditions prevalent within the field, the hospital administrator, of course, knows whether his own institution is able to do more for his workers, but he must realize that employes have a more or less definite conviction about it, too, and that frankness in this regard will sometimes eliminate many false conceptions and aid materially in negotiations. Also, mere unwillingness to make the effort necessary to improve financial position should not be used as an excuse for refusal to pay proper salaries and wages.

Factors in Successful Bargaining

From the experience of industry, it would seem that there are three factors of primary importance in the success of collective bargaining.

1. *Awareness of the background before beginning procedures.* If there has been friction or open antagonism, it will require considerable tact to change the attitude of those concerned.

2. *The sincerity with which management accepts the procedure.* If the hospital administrator feels that the union leaders are insincere, he is not likely to succeed well in getting a meeting of the minds. If he decides that he can't deal with the group, he will probably not make sufficient effort to do even a halfway good job of it.

3. *Recognition of the strength developed by the union organization and its leaders.* If either is weak and indefinite in its desires, there will be an unbalance of power which will color the results decidedly. Intelligent leadership in the union makes the bargaining easier.

Who Shall Represent the Union? Elected representatives should represent the union. It is in an effort to help obtain good leadership in the unions that various forms of union security have been requested in contracts. With a fixed nucleus of membership to be counted on for the union, budgets can be made and expenses can be planned intelligently so as to attract good leaders at fair salaries to handle the union's problems.

Theoretically, then, some system of maintaining their membership is important to labor unions. This is, apparently, extremely difficult to maintain without force of some kind, and so employers are being asked to provide that force by discharging those who do not maintain membership.

Maintenance of membership was granted for the first time in a hospital union dispute by the National War Labor Board in a decision in District VI on Oct. 14, 1943, in the case of seven hospitals in Minneapolis against Public Service Building Employes, Local No. 113. This is the mildest form of union security in that it does not necessitate a new employe's joining the union, but once he has joined it, he must continue to be a member in good standing during the life of the contract or run the risk of the union's demanding his dismissal. No pay roll check-off is involved.

What Should Be the Content of the Contract? If unions are accepted by hospitals on the basis of their possibilities for good, the terms of recognition must provide the following safeguards:

1. A mechanism for arbitration. Public safety and public health require unobstructed and unimpeded hospital service and striking against such service is outlawed. Furthermore, the union officials should clearly understand and accept their share of responsibility for making sure that service to patients does not suffer.

2. Assurance that jurisdictional disputes among craft, industrial and other groups will not interfere with hospital operations.

3. Agreement that employment procedures will be such as to leave hospitals free to employ the best qualified individuals for the care of the sick.

4. Understanding that discharge procedures will be impartial and fair but that the hospital retains the right to discharge for incompetence, inefficiency, dishonesty, inability to perform duties and for lack of other necessary personal attributes.

5. Agreement that the major subjects of negotiation shall be hours, wages, vacation and sickness allowances and other conditions of employment.

6. Grievance procedures must be definitely stated in the agreement.

Insurance: Help or Headache to the Business Office?

LAWRENCE BRETT
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IT IS usually accepted that hospitalization insurance has been good for both the policyholder and the hospital but, inevitably, each looks at the problem from a different point of view. The majority of patients admitted to hospitals in industrial areas are covered by some type of hospitalization which pays all or a part of the total bill, depending upon the cost of the coverage; these are usually group policies which may or may not include medical benefits.

Every hospital appreciates the theory behind hospitalization insurance, whether it is Blue Cross or some form of commercial coverage, but the popularity of any particular policy with the business office depends upon the insurance company's method of settling its claims.

The first big value of any type of insurance is to furnish a satisfactory "patient credit" upon admission of the patient; this is usually accomplished by the presentation of a card stating that the patient is a policyholder and giving his policy and group number. If there is no way for the hospital to check on the length of time for which the policyholder is covered before he leaves the hospital, the policy decreases in value to the hospital because this limitation is a handicap in figuring the "insurance credit" on a bill when the patient leaves and the balance, if any, that he will have to pay.

When there is any disagreement over the bill, the hospital usually loses because most people feel they have morally settled their account in full when they pay whatever is asked over the amount covered by insurance; if the hospital cannot correctly compute the amount to be paid by the insurance company, it is too bad.

The next headache for the poor cashier is to be presented with a policy written with ambiguous clauses and to have to say authoritatively that it will or will not cover this and that. What may be a perfectly comprehensible phrase to the company adjuster, who handles hundreds of cases with the same policy and similar circumstances, may be just the opposite to someone who handles only one or two such policies, with a different set of circumstances every time.

There Are So Many Forms

Near the top of the list of disagreeable features about almost any type of insurance are the number and complexity of forms to be filled out to complete the claim so that either the policyholder or the hospital is paid. Of course, the hospital is always in favor of insurance that is paid only to the hospital, but the most satisfactory policy would allow the *hospital* to determine whether the imbursement should be paid to it or to the policyholder in case the patient wished to settle the account in full upon leaving.

As the majority of Blue Cross plans obviate the need for a physical examination of the applicant by selling him the policy contingent upon the fact that he will not be hospitalized for chronic ailments of which he was aware before taking the policy, this premise puts the burden on the hospital to submit a fairly complete diagnosis or history of the case, usually signed by the doctor, when claim is made.

With all fairness to both insurance company and hospital, a long statement by the attending physician not only slows down the rapidity of collections for the hospital but makes that particular type of policy unpopular with the doctor as he must spend much of his valuable time filling out forms for which he receives small tangible reimbursement.

A logical question would be, why does it slow down hospital collections when the physician is right there? Most hospital staff members have their offices in town and only come to the hospital to attend their patients and it is hard for the business office to catch the doctor unless he must report somewhere. An admitting diagnosis for a preliminary authorization is a good compromise for both hospital and insurance company as it allows an adjuster to judge whether the claimant is suffering from a chronic illness that was known prior to the effective date of the policy and cuts the hospital's paper work down, allowing a more expeditious establishment of "insurance credit."

Any company that is overcautious in its settlement or goes into prolonged correspondence over a large percentage of claims not only is unpopular with the hospitals but is viewed with trepidation by its policyholders when the business office does not greet the presentation of its policy with smiling assurance. Prompt payment, with all it entails in the proper settlement of a claim, is one of the greatest aids to an insurance company's popularity with both the insured and the hospital.

When the whole claim is settled promptly, and an unpaid balance remains after the patient has left the hospital, the account is still new enough to make collection attempts effective and any correspondence about the account takes place before the patient has forgotten about the circumstances. A simplified system of presenting claims helps in the rapid settlement as few hospitals ever have enough help, and tardiness is not a characteristic of insurance claims departments only.

Contracts Can Help Hospitals

Many hospitals have contracts with both Blue Cross plans and commercial insurance companies and these policies are held by a sufficient number of people in the area to constitute a sizable percentage of the hospital insurance admissions. These contracts are usually mutually beneficial. The contract gives some discount to the insurance company on the claim and also gives the hospital a substantial basis on which to figure the amount of its service that is covered by the insurance without extra cost to the patient. In addition, the insurance may have given the hospital a new financial grip on life by cutting down its loss from low income level families. However, when a company exploits a hospital's good will by advertising that the policy coverage includes more services than are actually covered by the contract, the contract proves a liability rather than an asset.

In this period of rising patient day costs a contract prohibits the hospital from helping make up the loss on the difference between what is contracted for by the insurance coverage and the actual cost by collecting the balance from the patient. What actually happens is that, in this instance, the hospital cannot raise its advertised rates for the work that has been done.

Hospitalization insurance is a fine foundation for a firm financial structure as it guarantees the hospital the funds necessary to accept without reservation patients from lower income groups who are not indigent but who could not afford the total bill for hospital services. To make hospitalization the financial backlog it pretends to be, a closer understanding is necessary between those who write the policies and those who furnish the service.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

If I Were a Trustee

HOWARD R. TAYLOR
Student in Hospital Administration
Columbia University
New York City

Students in hospital administration enrolled at Columbia University School of Public Health were assigned the topic "If I Were a Trustee" as part of their course in trusteeship. From an unusually fine collection of essays on this subject, Mr. Taylor's was selected because of its lively, fresh presentation

AS A student in a formal course in hospital administration for the last four months, I have heard a variety of speakers on a variety of subjects. One note invariably finds its way into lectures and discussions of everything from staticproof operating room floors to bed endowments—trustees.

I have been told that trustees are wonderful people, complete with halos, intelligence and an admirable sense of social justice. Other lecturers have hinted in not too subtle a manner that trustees are stupid, selfish and a thoroughly despicable species of mankind. One bright note by a harassed administrator was that when he passed on to his reward in heaven, his troubles would be over as he would never again meet a trustee.

They Are Here to Stay

No doubt there are trustees of both varieties, but as the hospital trustee is apparently here to stay, those who wish to enter the field of hospital administration must accept the fact and learn to live with it.

Just as no trustee can reasonably expect his administrator completely to measure up to any of the frequently published lists of what the ideal administrator should be, neither can the administrator expect his trustee to be possessed of all the virtues it is possible to set down on a printed page as the ideal in total qualifications for a trustee. As ideal individuals seldom exist, there is little reason to expect to find them on a hospital board of trustees. With this in mind, were I suddenly elected to a hospital board of trustees, here is the way I should like to be.

First of all, I would have a sincere interest in those more unfortunate than myself. The sick and injured should arouse the interest and sympathy of us all and, by promoting the best in hospital care at the lowest possible cost, I would in some degree benefit these unfortunates and the community. By viewing the hospital as only a part of the total health program, I would endeavor to aid in the cooperation between the hospital and other health agencies in the community.

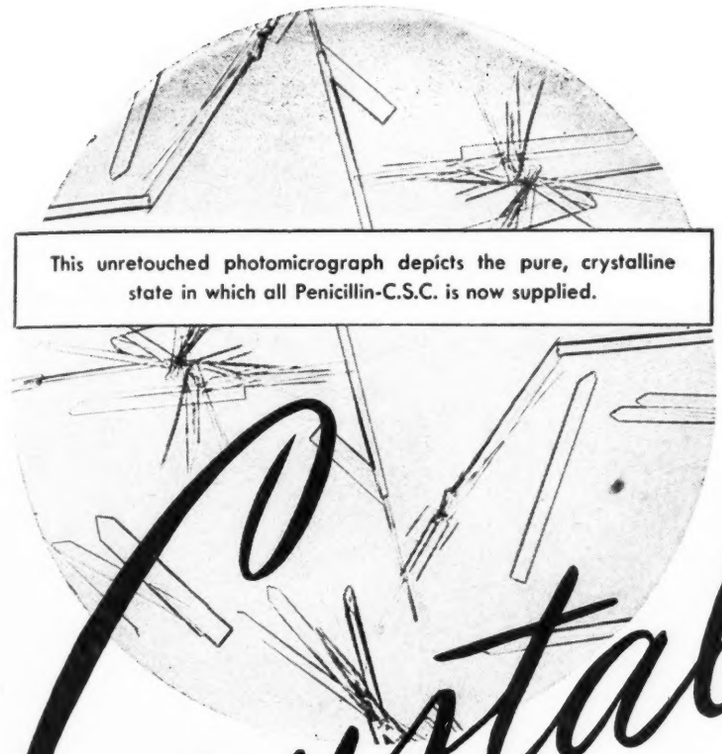
A realistic appreciation of my responsibilities as a trustee of an important community health utility would be most desirable. I would eschew the honor of election in favor of the opportunity to further the best interests of the hospital and the community, bearing in mind that the hospital belongs to the public, not to me. By cultivating a real interest in health and medical work and all auxiliary phases of running a hospital, I would better prepare myself for fully accepting my responsibilities.

While accepting all the duties delegated to me and executing them to the best of my ability, I would bear in mind that, as a trustee, I am not expected actually to run the hospital. There are many sincere and well meaning trustees at large today who by their ignorance or disregard of this fact are unwittingly inviting murder. The person to administer the hospital properly is, logically, the administrator.

Assuming that the administrator has been chosen wisely, my duties as a trustee can be performed to the best interest of all by cooperating with him, treating him as a partner in this hospital endeavor and respecting his position and judgment. I would try to remember at all times that if I expect the loyalty of the administrator, I, in turn, must be loyal to him. By recognizing where his responsibility begins and respecting that line by never overstepping it, an effective and mutually satisfying basis for carrying out the hospital's mission would have been established.

Offers Benefit of Experience

I would willingly contribute the benefits of experience in my private business or professional life and share that knowledge with the hospital. Because of the diversified activities found under the hospital roof, there are few specialties in business or professional life from which the hospital cannot draw valuable advice. While guiding the administrator and my fellow board members, when so qualified, I would not attempt to benefit financially from my position or my special knowledge at the expense of the hospital. While there may be isolated instances in which



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[1] "The potency of the penicillin undoubtedly affected the results. The first 15 patients, all treated with the same batch of penicillin, were cured. The next 7 patients were treated with the same dosage of a different batch of penicillin. Five of these 7 were not cured. Assays of penicillin used for these 7 patients showed it to be of reduced potency." Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, J.A.M.A. *130*: 628 (March 9) 1946.

Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units. It is also supplied in convenient "hospital packages" containing five vials of the same unitage.

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this would be impractical and to the disadvantage of the hospital, those instances are so rare as to make them "the exception that proves the rule."

While guiding the board and the administrator along my particular specialty, I would constantly strive to remember that I am not expert on all hospital affairs. To correct this condition and, by so doing, to become a better trustee, I would read current hospital literature in an attempt to educate myself in hospital and health matters.

Must Be Properly Informed

When he is first elected, the average trustee cannot be expected to be an expert on hospitals, but continued ignorance after the first year or two indicates that there is little interest in the hospital or that the trustee lacks the willingness to learn. By failing to be properly informed of at least the broad phases of hospital administration, the trustee can, instead of aiding the hospital, be harmful by failing to recognize its proper function in the health program of the community and thereby aiding in destroying the hospital's usefulness.

Future planning is essential for continued success of a hospital. Trustees with vision who plan for the future needs and growth are important and necessary to the hospital. With this knowledge, I would always attempt to look ahead in formulating policies and plans for the institution in order that progress of the hospital would not be retarded.

I would have a realization of my legal responsibilities as a hospital trustee. It would definitely guide my selection or approval of the administrator, the medical staff and other personnel of the hospital. By safeguarding myself, I would shield the hospital from legal action arising from improper selection of personnel.

A modern, realistic personnel policy for the hospital would be of great interest to me as a trustee. I would not expect the employes to contribute their time and energy without fair compensation, as is so often expected. Hospital employes have every reason to desire and expect the pay that comparable workers receive in the industrial field. My influence would be used in advancing such a personnel policy, with retirement plan, hospitalization benefits, adequate vacations and a living wage for every worker. These employes have a right to such a program.

While such a plan might seem directly opposed to furnishing medical care of the highest type at the lowest cost to the patient, truly high standards cannot be maintained when the hospital personnel is underpaid and therefore insecure and dissatisfied. While the patient rightly is considered first, the personnel cannot be ignored because eventually such action will adversely affect the hospital's ability to care for the patient adequately.

The hospital that is successful in carrying out its aim represents the ideal in cooperation. Like our national government, the hospital is made up of many smaller units, independent, yet unable to function alone, and all striving and working toward one goal, which in the hospital's case is caring for the patient. In spite of the seeming distance between the surgeon and the pot-washer in the kitchen, each is, in his own way, contributing to the patient's care. So it should be with the trustee. Although he has an important rôle in the hospital endeavor, he, too, is performing a job and to fulfill that job successfully he must cooperate with all others concerned, not viewing his position as a separate entity, a thing apart, but rather as a part of the whole.

To conclude, the trustee should be well informed, should recognize the rights of others and should be cooperative. With such qualifications the trustee should be of real value to his hospital and his community—and that is the way I would want to be if I were a trustee.

Question of the Month

Each month in this column one question bearing upon hospital trusteeship is presented and answered. The editor is glad to receive questions which any hospital trustee may submit. All identification will be withheld. Replies will be made by mail pending their publication.

QUESTION: At a recent meeting of our board, the suggestion was made that a member of our executive committee be appointed to represent us at the hospital association meeting in Philadelphia this fall. His attendance would be in addition to that of our administrator who always covers these events. Do you believe this to be a good idea and are trustees welcome at these meetings?—L.O.F.

ANSWER: The answer to both of your questions is "Yes." Greater attendance of trustees not only at the annual convention of the American Hospital Association but at regional hospital meetings has been urged in these columns on numerous occasions. With voluntary hospitals standing at the crossroads as they do today, it is vitally important that board members know the facts and acquire the necessary knowledge to influence public opinion in behalf of our voluntary institutions. No better opportunity is afforded to acquire such knowledge than attendance at the A.H.A. convention.

To get the most out of these meetings the trustee would do well to be guided by his administrator. There will be numerous sessions bearing on administrative or strictly professional subjects which do not concern the trustee and which he can very well skip. There will be others which he cannot afford to miss. It would be helpful if from the advance program the superintendent suggested to the board member what sessions he should attend, always with the idea of saving his time and efforts. Incidentally, time and opportunity should be afforded him to study the exhibits, also to talk with various hospital authorities.

Perhaps your question as to the benefits accruing from trustee attendance at hospital meetings may best be answered by rereading "I Went to the Convention" by Grant Simmons which appeared in December 1944 in the Trustee Forum.

Finally, there can be no doubt of the welcome accorded any trustee who will take the time and effort to familiarize himself with present day hospital problems.

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31

The Ideal Diabetic Unit:

Of the hospital but not in it

ELLIOTT P. JOSLIN, M.D.
Medical Director, George F. Baker Clinic
New England Deaconess Hospital, Boston

HENRY R. SHEPLEY
Architect, Coolidge, Shepley, Bulfinch and Abbott, Boston

DIABETIC patients who require treatment are of three types: (1) those ill enough to be in bed; (2) those needing hospital supervision, but for the greater part of the day ambulatory, and (3) transient, corresponding to cases customarily cared for in an outpatient department or a doctor's office.

A hospital for diabetics should be a unit in a large general hospital. Few diabetics of the first type die of their disease; they suffer and die from complications of diabetes and these complications require treatment by preeminent specialists, chiefly surgical. It is an understatement to say that one third have complications in the lower extremities. A considerable group requires abdominal operations.

Many of the older patients have operations upon the eyes; a notable percentage of the younger group presents abnormalities in throat, nose, ears and teeth, which should be corrected, and at least one in 50 needs thyroid surgery.

So manifold are the complications and so urgent is the demand for skilled surgeons and specialists to protect these vulnerable diabetics, who must be treated all the time for their diabetes, that association with a large hospital manned by a staff of repute is necessary.

Hospital provision for the type of diabetic cases just described is essentially the same as for surgical bed cases in any large hospital. But there are other serious medical complications to treat which are peculiar to the diabetic, namely, coma, hypoglycemia, neuritis, tuberculosis and nephritis, quite apart from the cardiovascular impairments to which the diabetic is heir. These cases also require bed care on account of their urgency.

In contrast to the group mentioned are the remaining actual diabetic admissions who are, to a large degree, ambulatory. They are waiting for or convalescing from operations, are under diagnostic observation or are in the clinic for inauguration or revision of treatment. For this second segment of the diabetic clientele less individual nursing is involved; many can go to a common dining room and, therefore, a less expensive and different type of construction is indicated.

There is a third group of diabetics for which provision should be made in the "Diabetic Hospital of Tomorrow." This third class of patients includes those diabetics who are transients and come for occasional visits to a doctor's office or a hospital outpatient department. They need detailed instruction in diet and insulin. Many could be given a temporary opportunity to obtain meals in a cafeteria or dining room and thereby be drilled in food portions. They could live at home or elsewhere outside of the hospital. In general, these patients should be recruited from those discharged from the indoor diabetic clinic and those living near the institution.

Education in Diabetes Essential for all Diabetics. Education in the management of diabetes and its prevention among the relatives of the patients should be the keynote of treatment planned for and emphasized from the day of admission to the day of discharge for each and every diabetic patient seen, irrespective of the group to which he belongs.

Personal responsibility for his own and his family's welfare should always be cultivated and in the foreground. Unless the diabetic is willing to assume this responsibility, time and money spent by or for him are largely wasted. I believe that the diabetic needs character building just as much as body building, if he is to survive and be a credit to the clinic and its doctors, to his relatives and himself.

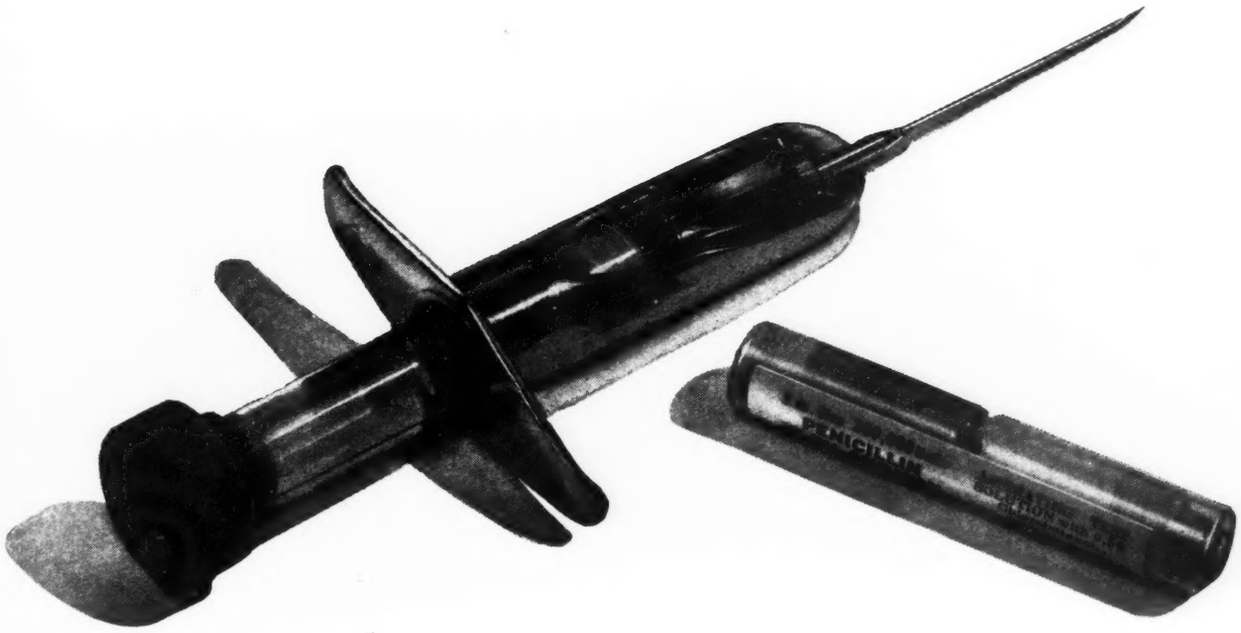
Preserve the Patient's Financial Independence. Fees. So far as possible, each patient should pay something for his care. It costs something to live at home and there is no reason why that same sum should not go to the hospital. If charity contributes to the support of the individual outside of the hospital, that same amount should be available toward costs while he is in the hospital.

We have a summer camp for diabetic girls. The first year they paid nothing. That was a mistake. We learned that the children and their parents did not wish to appear dependent. The next year they were allowed to pay and in the course of seventeen years they now contribute half the total expense, which this year was approximately $10,000 for four groups of 50 girls each for two weeks' stay.

The Laboratories — Routine and Research. The laboratory of a diabetic hospital does the medical bookkeeping for the patients. Its records and balance disclose the efficacy of treatment. The patient diabetically is doing well or ill and the laboratory sheets will show it. The routine clinical laboratory should be exalted to the importance it possessed in the Allen Era of Undernutrition, 1914-1922, when accurate reports showed minimal gains or lapses of carbohydrates and caloric tolerance.

The facts which the laboratory learns about a patient should be so carefully and promptly assembled as to command the respect of patient

A SIMPLIFIED *NEW* TECHNIQUE FOR PROVIDING



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1. Kirby, W. M. M.; Leifer, W.; Martin, S. P.; Rammelkamp, C. H., and Kinsman, J. M.: J.A.M.A. 129:940 (Dec. 1) 1945. 2. Romansky, M. J., and Rittman, G. E.: Science 100:196 (Sept. 1) 1944.

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and doctor alike and, as a rule, should be reported daily to each. The routine laboratory of a diabetic unit should be as scrupulously clean and as carefully supervised and organized as the adjoining laboratories for experimental investigation.

Research in diabetes is essential in any clinic if it expects to hold the confidence of its clientele or the enthusiasm of its staff and be a mecca for other doctors as well. Diabetics want their doctors to try to improve the treatment of their disease no matter in how modest a way. Therefore, not only must space be reserved for the routine laboratory commensurate with the number of admissions, but there should be rooms for special investigators. These would include accommodations for workers in pure chemistry, for a metabolism unit, for bacteriology and space for x-ray equipment or easy access to it. Four small and one larger room should suffice.

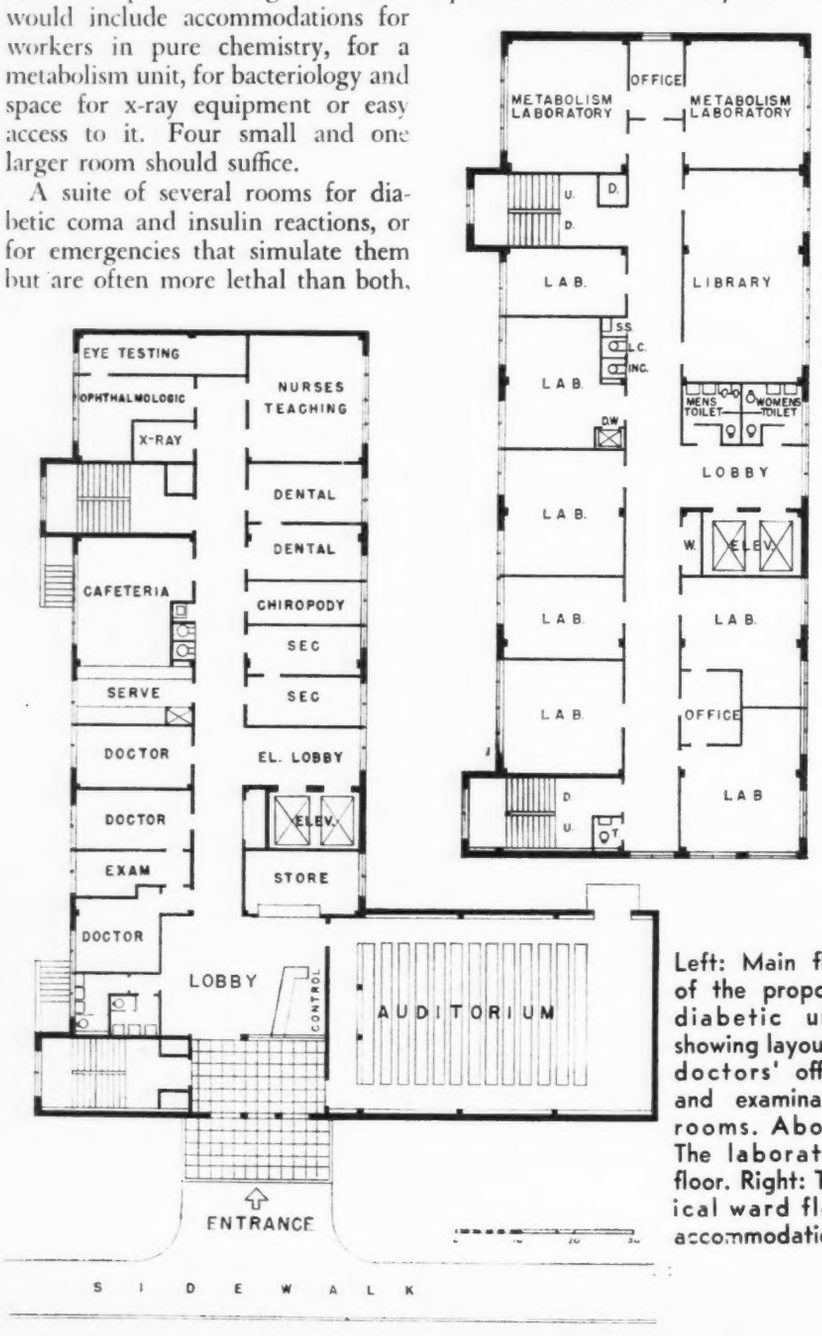
A suite of several rooms for diabetic coma and insulin reactions, or for emergencies that simulate them but are often more lethal than both, should be provided. Diabetics, not only in the vicinity of the hospital but also far afield, should be taught that in this diabetic hospital, during day and night, Sundays and holidays, facilities are ready at a moment's notice to save their lives. Every diabetic and his friends should always know where to go or be sent in an emergency.

Suggestions for Construction of a Diabetic Hospital Unit. At the New England Deaconess Hospital, Boston, a hospital of 300 bed capacity, we of the George F. Baker Diabetic Clinic have 75 beds for diabetics and are planning to add 50 more as soon as further funds are available.

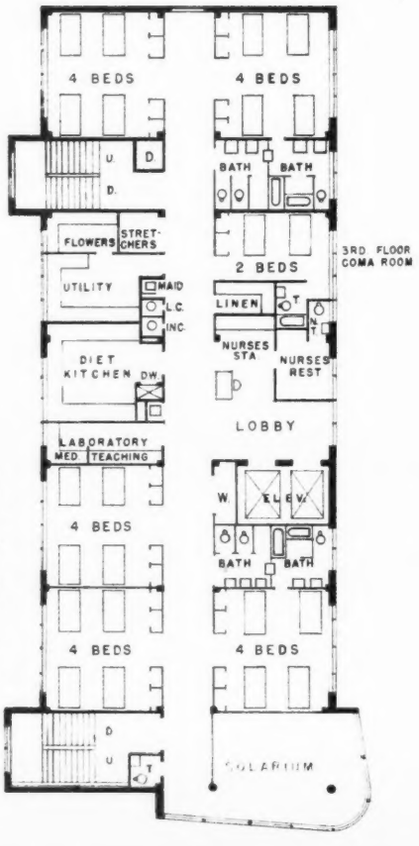
What should be the allocation of space in a diabetic hospital? We know we need our present 75 beds for seriously ill bed cases. At present these beds are distributed about as follows: four wards of eight beds each, four wards of four bed capacity two of three beds, five semiprivate rooms with two beds in each, and 11 private rooms. For our new diabetic unit of 50 beds we believe there should be two wards of eight beds each, four wards for four patients each, four semiprivate wards and 10 private rooms.

Diabetic Coma Unit. Virtually the most active diabetic clinical unit in the entire hospital and the one in which the most experienced nurses are in charge should be the diabetic coma and emergency unit of three or four beds, an appropriate laboratory of ample size amply equipped. Adjacent should be a private room and bath in which a doctor could work and sleep when emergency cases are under treatment because so often he is called upon to be with the patients all night long.

Teaching Laboratories. Close to each group of ward beds and private rooms should be small teaching laboratories where house officers and nurses could make simple urinary tests and teach patients technics. At least one such laboratory should be provided for each 12 or 15 patients.



Left: Main floor of the proposed diabetic unit, showing layout of doctors' offices and examination rooms. Above: The laboratory floor. Right: Typical ward floor accommodations.



"...Unto the Third and Fourth Generation..."

PROTECTION against congenital syphilis can often be accomplished by treatment of the expectant mother.

Proper antisyphilitic therapy during pregnancy can prevent or control syphilis in the infant . . . lower the mortality rate in fetal syphilis . . . reduce the frequency of premature labor—even if the antisyphilitic course is comparatively short and the child not cured. Syphilis in mothers can be well started toward symptomatic and serologic cure.

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Lavatories and Bathrooms. Lavatories and bathrooms should be far larger and far more liberally planned in a diabetic hospital than in an ordinary hospital. "The diabetic should be the cleanest citizen in the community." Special arrangements should be made for the collection of urines of both bed and ambulatory patients and for refrigeration. These arrangements should be so carefully planned that opportunities for error in collecting and measuring specimens should be minimal. The urines should be kept in the little teaching laboratories described.

Diet Kitchens. Kitchens, and particularly food service rooms, should be larger than in the general hospital, because the diets must be weighed. An adjoining alcove should be provided for the easy instruction of individual patients. Presumably the food would be prepared in the central hospital kitchen.

Insulin and Medication Rooms. These are needed for the exclusive use of the nurses. One such room should serve 20 patients. It should contain equipment for the cleaning and sterilization of syringes.

Cafeteria. Cafeteria dining rooms should be available, one for ambulatory cases in the hospital and another, adjacent to the first, for transient cases temporarily living outside the hospital yet under treatment. If possible, the latter should be on the ground floor to avoid the use of an elevator.

Visiting Rooms. Sun parlors, piazzas and small rather than large visiting rooms should be available. In these rooms doctors, too, can confer with relatives.

Children's Ward. The children's ward need not be large. Less than one tenth of a diabetic clientele is made up of patients with onset of the disease under 15 years of age. On the other hand, these are the patients who live the longest, their life expectancy taking them well above an ultimate age of 50 years.

In the hospital they should not be in contact with other children, in order to minimize errors in dietary control. They should be by themselves, in a safe part of the hospital, away from proximity to the elevator or outdoor exits, but close to a sunny playroom and porch, including gymnastic equipment.

Ophthalmology. An ophthalmologic unit consisting of several two bed wards and private rooms is most desirable. If the eye cases can be treated in one locality in the hospital, great efficiency is promoted because the nursing personnel will be trained in giving them expert attention, thereby obviating the need for a private nurse for each one.

Obstetrical Provision. Our diabetic pregnancy cases are often kept in the hospital for two weeks, more or less, prior to delivery and then transferred to Faulkner Hospital, which specializes in obstetrical work. That is proper for us, because in our hospital we have no obstetric service. Between Jan. 1, 1936, and Oct. 15, 1945, 250 such patients have been so treated and at this writing we have under supervision 40 pregnant but undelivered women. The number requiring hospital bed care seldom exceeds four.

Tuberculosis. Tuberculosis cases we hope to treat in a separate building in the Channing Home, which adjoins New England Deaconess Hospital. Its trustees have voted in favor of amalgamating with New England Deaconess Hospital, yet preserving its own identity. There will always be need for such accommodations.

Space for the diabetic coma unit, for children, for ophthalmologic and obstetric patients and those with tuberculosis is included in our proposed 50 bed addition.

Rooms for Chiropody. Care of the feet is so essential that one room for chiropody should be available.

Dental Rooms. Dental rooms should be provided. One operating room and one recovery and preparation room, which serves as the dental hygienist's office, suffice for our present 75 beds.

Diabetic Classroom and Instruction Rooms. A diabetic classroom suitable for 60 patients, their relatives, friends and medical visitors should be on the first floor. Near by should be two rooms, each fitted with modest laboratory equipment, for teaching diabetic nurses. These also could be utilized as examining rooms by physicians.

Doctors' Offices. The offices of the doctors and the staff should be unpretentious with two or more examining rooms, depending upon whether the doctors use them also for their extramural practice. At least two rooms for the secretarial staff should be available near by. Space can be saved if offices for doctors, nurses and secretaries are adjacent.

Library. A library for a small collection of periodicals and books is desirable and will be utilized. It should be so ample in size that it will provide space for large working tables for doctors or secretaries working on research problems.

Hospital Diabetic Store. A hospital pharmacy store in which patients can purchase supplies is most advantageous, but this need not necessarily be apart from any such store designed for all patients. However, the diabetic patients will patronize such a store far more than will others in the hospital and the profits on diabetic purchases will help materially in providing care for needy patients.

Arrangements for keeping animals in various departments of the hospital should be planned for the roof where there would be sunshine and fresh air and avoidance of odors.

The plans that accompany this paper in general fit the text.

We have conceived this building as a separate clinical, research and teaching unit which could be erected as a part of the expansion program of the New England Deaconess Hospital. Some of the features, therefore, described in the text in this specific instance could be more appropriately located in the main hospital unit. Obviously, one would take advantage of the combined x-ray department, pathological and general laboratories.

Economy alone favors housing all patients of all types under one roof, but so far as diabetic patients are concerned, particularly those of the ambulatory type, a separate building is desirable because in it they can be treated less expensively. At the moment, its smaller size will allow it to be erected more promptly and thus alleviate the shortage of beds. Moreover, there is the great psychological advantage of a distinct diabetic unit, because then the patients can see what is being done for them and how the money which they have given to the hospital has been spent. The mere knowledge that there is such a clinical, research and teaching unit designed for diabetic patients in one part of the country will, we hope, help to stimulate the construction of similar units in other localities.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago

Intestinal Antiseptics

IN THE past medicine has seen the introduction of numerous so-called "intestinal antiseptics," such as phenylsalicylate ("salol"), methenamine ("urotropin") and methylene blue, but the introduction of sulfaguanidine in 1940 by Marshall of Johns Hopkins University was the first practical step in an attempt at intestinal bacteriostasis.

At the present time it has been largely superseded by less toxic and more effective sulfonamides, such as sulfadiazine, succinylsulfathiazole (sulfasuxidine) and phthalylsulfathiazole (sulfathalidine).

The discovery by Poth of Galveston, Tex., that sulfasuxidine and sulfathalidine were retained in the gastrointestinal tract and exerted a profound bacteriostatic effect has led to the wide usage of these drugs in bacillary dysentery, ulcerative colitis, regional enteritis, chronic cystitis and the preoperative preparation and postoperative treatment of patients undergoing surgery of the large bowel.

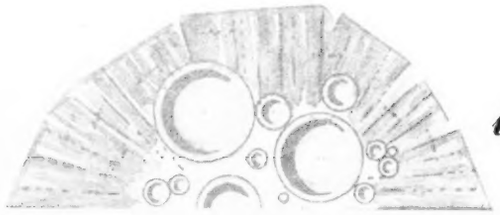
Pharmacological Activity. Sulfasuxidine and sulfathalidine resemble each other chemically and pharmacologically in many respects. They are dibasic acid conjugates of sulfathiazole, approximately 95 per cent of the orally administered dose probably remains in the gastrointestinal tract and each exerts a strong bacteriostatic effect on and reduces the numbers of certain types of microorganisms residing in the bowel.

Because these compounds have free carboxyl groups (—COOH) they readily form soluble salts and are present in high concentration in the fecal stream. The presence of the carboxyl group in the molecule is apparently essential in preventing the absorption of these drugs from the intestine.

The extremely small percentage of the ingested drug which is absorbed from the small intestine either is returned to the gut lumen via the bile from the liver or is excreted by the kidney. Renal complications are rare because of the small amounts of drug excreted by the kidney and the highly soluble character of the basic salts. Blood levels remain low and range from less than 1 to 2 mgm. per cent.

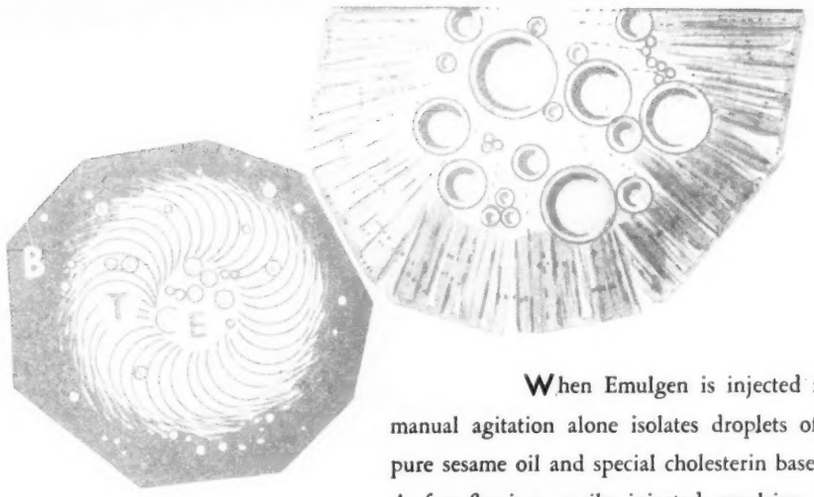
The mode of action of these drugs has not been conclusively explained. They are devoid of bacteriostatic activity *in vitro;* however, they become powerful bacteriostatic agents when introduced into the lumen of the intestine. The simplest explanation that the dicarboxylic acid radicle is split off, releasing the sulfathiazole in high local concentration, is not wholly supported by observations on the relative rates of hydrolysis *in vitro* of the different derivatives in this series of compounds.

For example, it is difficult to explain the effectiveness of sulfasuxidine in eliminating drug-resistant carriers of Shigella paradysenteriae, Flexner and Shigella sonnei when one considers that *in vitro* some of these cultures are resistant to concentrations of sulfonamide greater than 250 mgm. per cent. The sulfathiazole concentration in the feces of patients taking sulfasuxidine ranges from less than 50 to as high as 200 mgm. per cent. It would appear that the hydrolysis of these compounds to sulfathiazole does not entirely explain this specific type of bacteriostasis.



the injection vehicle for

SLOWER PENICILLIN ABSORPTION



Schematically, aqueous penicillin bearing droplets **E** injected into the muscle are released slowly through the tissues **T** into the blood **B** as the enveloping sesame oil emulsion (Emulgen) is absorbed.

When Emulgen is injected into a vial of penicillin solution manual agitation alone isolates droplets of penicillin-bearing water in the pure sesame oil and special cholesterin base of this new emulsifying vehicle. A free-flowing, easily injected emulsion thus is formed quickly and at room temperature.

After the creamy water-in-oil emulsion formed by Emulgen has been deposited in intramuscular tissue the fine droplets of penicillin solution pass into circulation only as their lipid sheaths are absorbed. Utilization of the injected dose of penicillin is greatly prolonged so that convenient 8 to 12 hour intervals may separate injections.

The repository injection of penicillin is quickly prepared with Emulgen. Emulgen gives a uniformly creamy emulsion which is easily injected. This emulsion disappears from the injection site at a uniform rate releasing the last of its penicillin content shortly before the time at which destruction of the penicillin by body heat begins serious inroads on the remaining dose. Emulgen is supplied in 10 cc rubber capped vials. Lakeside Laboratories, Milwaukee 1, Wisconsin.

EMULGEN

LAKESIDE

Toxicity: Sulfasuxidine and sulfathalidine are the least toxic of any of the sulfonamides accepted for clinical use today. Bargen of Rochester, Minn., has found that the incidence of toxic reactions to sulfasuxidine approximates 1 per cent while reactions to sulfathalidine are even more rare. The severest types of idiosyncrasy to the sulfonamides, namely, hemolytic anemia, crystalluria and exfoliative dermatitis, have not been encountered. Only one case of fatal agranulocytosis has been reported. In this instance sulfasuxidine was administered to a patient known to be hypersensitive to sulfathiazole.

Patients who have developed a high degree of hypersensitivity from previous sulfonamide medication may thus show the usual untoward reactions. However, patients sensitive to sulfathiazole, sulfadiazine and sulfaguanidine have tolerated sulfasuxidine and sulfathalidine, and patients showing reactions to sulfasuxidine have taken sulfathalidine with no untoward effects. Patients have received these drugs daily for over a year's time without evidence of acute or chronic intoxication.

Clinical Application: Sulfasuxidine is usually administered in 3 gram doses every four hours day and night. This constitutes a daily total dose of 18 grams. In some cases the consumption of such large quantities presents a difficult problem for the patient. This is not encountered with sulfathalidine, for a dose of 1.5 grams every four hours produces an equivalent bacteriostatic effect. Some investigators find that a total daily dose of from 3 to 6 grams is adequate.

Sulfasuxidine and sulfathalidine are being widely used as adjuvants in the preoperative preparation and postoperative treatment of patients undergoing surgery of the large bowel. There is now evident a definite trend toward one stage procedures with direct bowel anastomoses. Open anastomoses of the colon are now performed with a degree of safety from abscess and peritonitis hitherto unobtainable.

It should be reemphasized, however, that these drugs are in no way considered as substitutes for sound surgical principles. These drugs should be administered in full therapeutic doses until the coliform count has dropped to 1000 or fewer colonies per gram of wet feces. If bacteriological analysis cannot be performed, drug administration should continue for at least seven days, at which time there should be a loss of fecal odor of the stool and a change in the consistency—the stool becoming much softer.

Wide interest has been observed in the treatment of ulcerative colitis, with the most extensive experience credited to Bargen and to Streicher at the University of Illinois. In these idiopathic conditions sulfathalidine has been found to be of definite benefit in inducing and prolonging remissions and improving the physical status of a high percentage of the patients treated. Because of the idiopathic nature of this condition it may be expected that this drug will fail to give improvement in certain types of cases, but it is encouraging to note the many favorable reports.

Both drugs have been especially useful in controlling intractable nonspecific diarrheas. Sulfathalidine appears to be best suited for treating these cases, although Twyman and Horton of Indianapolis report on the treatment of an outbreak of infantile diarrhea with sulfasuxidine which demonstrated the effectiveness of these nonabsorbable sulfonamides. It may be anticipated that the application of these drugs will do much toward curbing the morbidity in epidemics of this type. The risk of renal calculi is greatly enhanced if one of the absorbable types of sulfonamide (such as sulfadiazine) is used since urinary output is often greatly diminished owning to the dehydrating effect of the diarrhea.

While sulfadiazine is considered by Hardy of the U. S. Public Health Service as the drug of choice in the treatment of bacillary dysenteries, he and others have found that sulfasuxidine was the only drug capable of eradicating highly resistant carrier states resulting to Flexner and Sonne types of Shigella. Bernheimer of New York has found from the examination of 219 strains of Shigella that 17 exhibited a high degree of drug resistance *in vitro* to sulfadiazine. Many of these cultures were isolated from service personnel who showed no therapeutic response to sulfadiazine therapy.

Future Developments: A series of five sulfathiazole derivatives with —COOH, $—CH_3$ and $—CH_2COOH$ substituents on the 4 and 5 position of thiazole ring has been found by Poth and Ross to be potent intestinal bacteriostatic agents. The most potent of the series was the sulfa-4,5-dicarboxythiazole with the sulfa-5-carboxythiazole ranking next in activity. These investigations were carried out in dogs. Harris and Finland obtained good therapeutic responses in a series of cases of human bacillary dysentery treated with the sulfa-5-carboxythiazole. The sulfa-carboxythiazoles and sulfathiadiazole have been investigated by White using mice.

Most recently Winnek has investigated the sulfa-5-carboxythiazole and indicates that it possesses considerable chemotherapeutic activity in the gastrointestinal tract. It is hoped that future investigations will reveal that these or similar new compounds will possess specific activity against certain bacteria and viruses which are incurable today.

The exact status of streptomycin as an intestinal antiseptic is as yet not determined. It does appear to exert a strong bacteriostatic action in the intestinal tract. The few preliminary reports indicate that certain bacteria readily develop resistance to streptomycin; however, nothing conclusive can be stated until larger quantities of this antibiotic become available for experimental studies.—C. A. Ross.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Cross Infection in Wards

In the May 4 issue of the *British Medical Journal* there appears a report by the "Ad Hoc" Committee of the British Pediatric Association on cross infections in children's wards.

The main sources of cross infections are (1) manifest clinical cases, (2) a patient who is incubating a disease, (3) the ambulant, missed or subclinical case unrecognized because of its mildness and (4) the carrier who may be convalescent or "healthy." The last group may include both doctors and nurses.

All children should be examined by an experienced medical officer before they enter the ward. Attention must be paid to the throat, nose, ears and skin. Throat swabs should be taken routinely and, if necessary, swabs of the bowel, skin and nose. If there is the slightest suspicion of infection the patients should be isolated.

We are told that burn cases, eye, ear, nose and throat cases and those with otorrhoea should not be admitted to an open ward. These children should be isolated; also infants less than a year old should be admitted only to isolation rooms or cubicles. The supervisor in charge of the ward should have training in pediatrics. She should not have more than 20 acutely sick children under her care at one time.

We are told that leaving probationer nurses in charge of a ward at night is often responsible for a breakdown in anti-infection measures.—JOHN F. CRANE.

Sample Meals Show

Dietary Deficiencies

in Tuberculosis Hospitals

JANE SEDGWICK

Food Administrator, California Youth Authority and Department of Corrections, Sacramento, Calif.

DIETARIES of 34 tuberculosis hospitals throughout the state of California were studied during 1943 and 1944 by nutritionists on the staff of the California State Department of Public Health.[1] The survey in each institution had as its aim a determination of the nutritional adequacy by means of a method employing nutritional accounting.[2]

One day's food, including standard nourishments, was weighed or measured. A sample meal from the general patients' menu was drawn during food service. Calculations were made to determine the specific food nutrients supplied. In some instances two days' food was studied and in one hospital the average pounds of food in the 15 large food groups per person per day was determined from the usage for a month.

One day's menu is only an approximate indication of the adequacy of the diet. Greater accuracy can be obtained in the determination of the adequacy of the food offered if the amount used for a period of four weeks is studied.

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[1]Reports of Dietary Studies of Sanatoriums are on file in the Bureau of Tuberculosis, California State Department of Public Health.

[2]Sedgwick, Jane: The Berryman-Howe Method of Calculating the Nutritive Value of Diets in Large Scale Feeding, Bulletin of the California Dietetics Association **12:1** (Spring Issue) 1945.

Recommended Daily Allowances for Specific Food Nutrients for Tuberculous Patients

Specific Nutrient	*Ration Less Cooking Loss*
Calories	2500
Protein, Gm.	85 to 125
Calcium, Gm.	0.8
Iron, mg.	12.0
Vitamin A, I.U.	5000
Thiamine, mg.	1.5
Riboflavin, mg.	2.2
Niacin, mg.	15.0
Ascorbic acid, mg.	100 to 125

Food Group	*Pounds per Person per Day*
Meat, fish and poultry (carcass weight)	0.70
Eggs (1)	0.125
Milk and milk products (34½ fluid oz.)	2.16
Butter	0.045
Other fats	0.03
Grain products	0.20
Legumes, dry	0.02
Sugars and sirups	0.12
Vegetables, yellow, green, leafy	0.40
Tomatoes	0.157
Citrus	0.75
Potatoes	0.33
Other vegetables not included above	0.33
Fruits other than citrus	0.14
Dried fruit	0.01

A standard for the recommended allowance of specific food nutrients for tuberculous patients was selected by Dr. Edward Kupka, chief of the bureau of tuberculosis of the California State Department of Public Health. This standard was based on the "Recommended Daily Allowances for Specific Food Nutrients" furnished as a yardstick by the food and nutrition board of the National Research Council for the sedentary man.

Dr. Kupka increased the protein and ascorbic acid allowance above the recommended needs of the sedentary man after consultation with tuberculosis specialists at the medical schools of Stanford University and the University of California. The results of the calculations of the day's dietary served were compared with the accompanying standard.

These specific food nutrients can easily be supplied by the accompanying quantities of natural food per person per day by selecting amounts from the large food groups. Common foods may be arranged by classes or groups on the basis of similar nutritive content or of unique contribution to the diet.

Dietary reports were obtained on 30 of the 34 hospitals studied. Twenty-two of these hospitals employed dietitians. A study of the dietary evaluations as compared with the standard revealed the following information:

Calories. Sixteen, or more than half, of the hospitals were found to be below the recommended allowance for the daily calorie intake. Eight were within a range of 10 per cent plus or minus of the recommended level of intake. Five were more than 10 per cent above the recommendation. The lowest calorie intake available was 1605 and the highest, 3695.

Protein. Ten hospitals fell below the lower limit recommended for protein. Two were 18 per cent and

20 per cent below the lower limit. Twenty fell within the recommended range.

Calcium. No hospitals fell below the recommendation; eight were adequate, and seven had more than 10 per cent above the requirement. One hospital had 180 per cent of the recommendation.

Vitamin A. Only one hospital fell below the recommended standard; 22 were within 10 per cent above the recommended amount, and seven were more than 10 per cent above, some as much as 300 per cent.

Thiamine. This specific nutrient was low in 18 of the 30 hospitals. Four were within 10 per cent of the requirement and eight were more than 10 per cent above the requirement.

Riboflavin. None of the hospitals showed a shortage of this vitamin. This would not be unexpected because of the high intake of milk, which also furnished the high calcium content of the diets. Thirteen hospitals were within the range of 10 per cent above the recommendation. Seventeen were very much above, a few as high as 70 per cent above the requirement.

Niacin. Only six of the dietaries were studied for niacin and all were below the recommendation.

Ascorbic Acid. Although this food nutrient has been stressed in the treatment of tuberculosis, 17 of the 30 hospitals studied were low in this respect, some of them as low as 70 per cent below the recommendation. Six fell within a range of 10 per cent above and five were more than 10 per cent above the recommended allowance.

Niacin Content Low

The outstanding deficiencies were shortages of calories, protein, thiamine and ascorbic acid. Niacin was studied in only a few of the hospital dietaries, but it is significant that those that were studied were low. Inadequate protein would go hand in hand with a shortage of thiamine and niacin, as it is in those foods which are protein-rich that the largest supply of these vitamins is found.

The conclusions which may be drawn as a result of this study may be stated as follows:

1. Hospitals are convinced of the importance of serving milk. This results in adequate calcium and riboflavin.

2. Inadequate calories, protein, thiamine and ascorbic acid in from 30 to more than 50 per cent of the hospital dietaries studied indicates that considerable change needs to be made in the quantity and kind of food served in these hospitals. The employment of a dietitian does not seem to ensure the adequacy of the diet served.

There is a need for a rapid and fairly accurate method of determining the approximate nutritive value of diets served in a hospital over a period of time. Nutritional accounting may be used as a measure of adequacy of the diet in conjunction with cost accounting.

It is recommended that hospitals that serve patients for a period longer than ten days establish some method of calculating the nutritive value of the food used in relation to the number of persons served. A ration per man per day can be established which can be used as a yardstick for measuring the adequacy of the diet and can also be used to order and issue supplies for use in the institution over a period of a day, week or month.

Preparation of Food

It is possible to have an adequate daily menu in relation to the specific food nutrients, but this menu may become inadequate through poor food preparation.

Food preparation includes all processes through which food passes up to the time it is served. It includes the use of formulas to prepare uniform dishes on the menu and care in preparation to conserve nutritive value of the food. This is particularly true of the heat-labile B vitamins (thiamine and niacin) which are destroyed by prolonged cooking at high temperatures, and of the water soluble vitamins B and C of which the loss in cooking water may be extensive.

Proper food preparation also requires the avoidance of excessive trimming losses in preparation; prevention of pilfering, theft and handouts; eye appeal by use of individual portions, garnishes, toast and other devices; having all menu items ready on time but not too far ahead of time, and making all food as nearly as possible comparable to accepted standards which ensure palatability by the development of a pleasant taste and an appetizing flavor.

The methods of food preparation were judged on the basis of the foregoing standards and, of the 30 hospitals studied, methods of food preparation were judged decidedly poor in four (two of these employed dietitians), fair in nine and good in 17. Lack of authority or lack of adequate nutritional information is the cause of poor food preparation when dietitians are employed. It might be desirable to make available to these hospitals a consulting dietitian who can improve methods of food preparation and encourage more adequate diets.

Menu Planning

Variety, color and flavor are extremely important in menus for the tuberculous patient. He remains in the hospital months on end and the food can become extremely monotonous if it is not carefully planned. Only one day's menu was listed in the dietary reports of the hospitals; however, such comments as these are found in the reports:

"There is lack of imagination in the planning of meals. The same combinations are repeated again and again. A check of a year of the menus will show that the supper meals are particularly monotonous; meals are repeated and flavors are repeated in the same meal."

"Menus were checked for thirteen consecutive weeks. . . . A record of the main dishes served at dinner and supper indicated that there was no great repetition of food served or of food combinations."

In all but two or three places, more whole grain cereals should be used. Also, there is a need for more high vitamin C juices, fruits and vegetables. These should be substituted for some of the milk beverages used between meals. Too much milk is found in many menus. This takes away the appetite of the patient for more solid foods. More than a quart a day was served to the patients in the majority of hospitals. This should be cut to a maximum of one quart per person per day, including the milk used in cooking.

Miscellaneous Information

In addition to the topics already discussed, the reports contained comments on special diets, nourishments, food purchasing, kitchen equipment, meal hours, food service and the use of vitamin concentrates.

Meat Board study reveals these

Facts About Frozen Meats

REBA STAGGS
Director, Department of Home Economics
National Livestock and Meat Board, Chicago

LET us look to the time when supply and distribution of meat are again normal. Frozen foods are without question a subject of increasing interest. During and since the war a large number of studies have been conducted, and others are in progress, on the subject of freezing meats and marketing them after freezing. The acceptance by consumers will largely determine the extent to which meats are marketed in the frozen state.

Two Year Study Made

With frozen meats on the market, directions for defrosting and cooking them will be needed. Little research has been done on handling, defrosting and cooking frozen meats and the effects of various methods on the shrinkage, palatability and nutritive value of the finished product. With this picture in mind, the National Live Stock and Meat Board gave a grant to Iowa State College for a study under the direction of Belle Lowe. For two years, she has been working on frozen cuts of beef, pork, lamb and veal cooked by the various methods: roasting, broiling, panbroiling and cooking in water. When the study is complete, we shall be able to answer many of the questions which confront those who prepare frozen meat.

We are anxious to learn: (1) how meat should be defrosted, whether during or before cooking, and, if before cooking, whether it should be defrosted in the refrigerator, at room temperature, in water, wrapped or unwrapped; (2) how the method of defrosting will affect cooking time, cooking losses and palatability of meat.

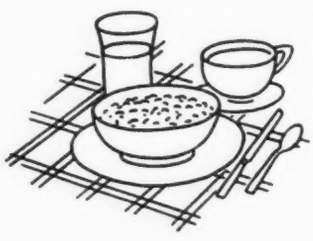
The work on beef is complete and that on the other meats is still in progress. The results to date indicate the following:

In general, palatability is not affected by the time or method of defrosting. In addition, no palatability differences are observed for roasts because of the type of fuel used. Losses in weight are about the same whether the cut is defrosted during or prior to cooking. The cuts that are frozen at the start of the cooking period usually have greater actual cooking losses. However, in the cuts thawed prior to cooking, the loss during defrosting plus the cooking loss gives a total weight loss about equal to that of corresponding cuts which are defrosted during cooking. In other words, the final loss for frozen meats that have been cooked is approximately the same, regardless of how they are defrosted.

The cooking time for the cuts defrosted during cooking is longer than for the cuts defrosted prior to cooking. Thus, the cuts defrosted during cooking require more fuel.

The time required for defrosting is affected to the greatest extent by the following factors: the defrosting temperature, the dimensions or size of the cut and the mass or total weight and whether the cut is wrapped or unwrapped.

The defrosting time in all cases is that period required by the meat to reach an interior temperature of 4° C. (39.2° F.). The defrosting time is much shorter during cooking than when a similar cut is defrosted by the other methods, but the time for defrosting during cooking also depends on the cooking temperature—the lower the cooking temperature the longer the defrosting time—if similar cuts of the same size are used.



More time is required for defrosting in the refrigerator than for defrosting by cooking, in water or at room temperature. For roasts and cuts which are not to be cooked in water, the amount of water used for defrosting is twice the weight of the cut. In these cases, since water conducts heat faster than does air, the cuts defrost in less time than at room temperature.

The time of defrosting depends on the size of the cut or the distance the heat has to travel to the center of the cut. For example, ½ inch steaks defrost more rapidly than do 1 inch steaks, and 1 inch, more rapidly than do 2 inch.

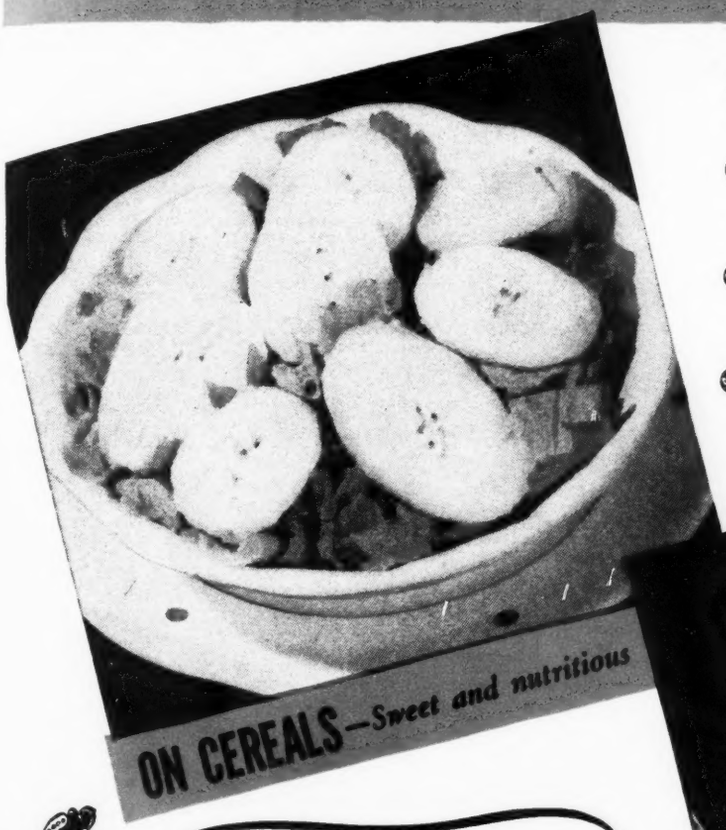
Mass Determines Defrosting Time

The mass or weight also affects the defrosting time of cuts. For example, a piece of meat 1 inch in thickness and weighing ½ pound defrosts faster than does a similar piece of the same thickness but weighing 1 or more pounds. Wrapped meat requires more time to defrost and the length of time is determined by the thickness of the paper and the number of layers of wrapping.

From these results, it appears that time and convenience are the two important factors to be considered. However, before definite recommendations can be made for defrosting and cooking frozen meats, it is necessary that a study be conducted on the effect of these methods on nutritive value.

From a paper presented at the 1946 Tri-State Hospital Assembly, Chicago.

BANANAS...a natural sweetener



ON CEREALS—*Sweet and nutritious*

● One fully ripe banana (yellow peel, flecked with brown), average size, contains the equivalent of 5 level teaspoons granulated sugar—as follows:

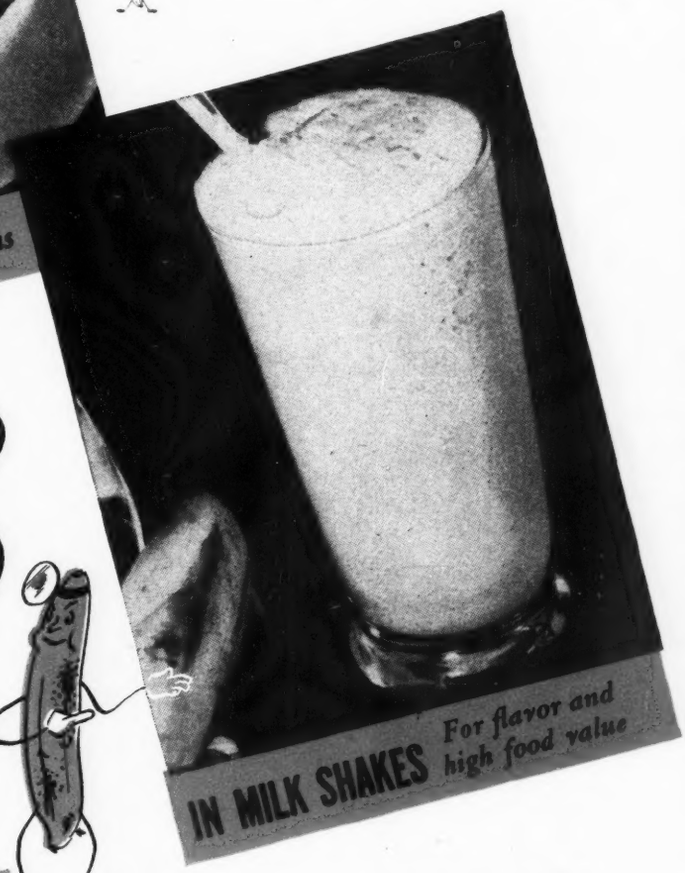
4.6% dext ose 3.6% levulose 12.2% sucrose	Total sugars 20.4%

PLUS

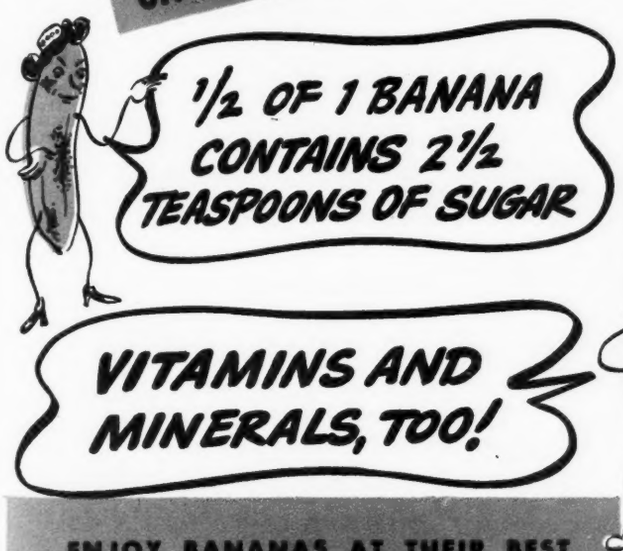
Vitamin A	310-420 International Units
Thiamin (B_1)	52-67 Micrograms
Riboflavin (G)	110 Micrograms
Niacin	.75 Milligrams
Ascorbic Acid (C)	12.5-13.7 Milligrams

PLUS

11 Essential Minerals — 120 Calories



IN MILK SHAKES *For flavor and high food value*



ENJOY BANANAS AT THEIR BEST

DO	let them ripen at comfortable room temperature.
DON'T	put them in the refrigerator because this prevents proper ripening.
KNOW	that bananas are fully ripe when the golden peel is flecked with brown.

UNITED FRUIT COMPANY

Banana Milk Shake

(290 CALORIES)

1 fully ripe banana* — **1 cup COLD milk**

**Use fully ripe banana . . . peel well flecked with brown*

Peel banana. Slice into a bowl and beat with electric mixer or rotary egg beater until smooth and creamy. Add milk and mix thoroughly. Serve COLD. Makes a 10 to 12 ounce drink.

NOTE: If electric drink mixer, which crushes fruit while mixing, is used, break banana into mixer cup, add milk and mix. Add ice cream before mixing, if desired.

Menus for October 1946

Irene Sakacs
Good Samaritan Hospital
Phoenix, Ariz.

1
Fresh Grapefruit Juice
Scrambled Eggs
•
Roast Lamb, Brown Gravy
Mashed Potatoes
Parslied Carrots
Lettuce Wedge With
French Dressing
Orange Cake With
Nutmeg Sauce
•
Cream of Spinach Soup
Macaroni and Cheese
Stewed Tomatoes
Asparagus Salad
Gelatin and Cookies

2
Stewed Prunes
Soft Cooked Eggs
•
Braised Beef
Browned Potatoes
Fresh Frozen Green Beans
With Creole Sauce
Orange-Avocado Salad
Butterscotch Pudding
•
Tomato Bouillon
Grilled Spiced Ham
Escalloped Vegetables
Blushing Pear Salad
Chocolate Iced Cupcakes

3
Grapefruit Halves
Shirred Eggs
•
Fricassee of Chicken
Mashed Potatoes
Buttered Fresh Frozen
Peas
Princess Salad
Blueberry Cobbler
•
Chicken Soup
Spaghetti With Meat
Balls
Spinach With Lemon Slice
Combination Salad
Strawberry Junket

4
Orange Juice
Omelet With Jelly
•
Fillet of Sole With
Tartare Sauce
Escalloped Potatoes
Buttered Asparagus
Carrot-Raisin Salad
Pineapple Sherbet
•
Vegetable Soup
Tuna and Noodle Casserole
Buttered Diced Beets
Stuffed Celery Salad
Fruit Cup With Cookies

5
Applesauce
Bacon
•
Pot Roast of Beef
Parsley Buttered Potatoes
Buttered Broccoli
Apricot and Cream Cheese
Salad
Gingerbread
•
V-8 Juice
Frankfurter Casserole
Sliced Tomatoes, Sweet
Pickles and Carrot Sticks
Chocolate Pudding

6
Bananas
Soft Cooked Eggs
•
Baked Ham With Raisin
Sauce
Mashed Potatoes
Buttered Green Beans
Lettuce Salad, Thousand
Island Dressing
Strawberry Sundae
•
Cream of Tomato Soup
Assorted Cold Cuts
Deviled Eggs
Potato Salad
Cupcake Surprise

7
Orange Halves
Bacon
•
Veal Roast With
Dressing and Gravy
Pimiento Potatoes
Glazed Carrots
Coleslaw
Lemon Pudding
•
Beef-Noodle Soup
Ham Omelet With
Creole Sauce
Buttered Asparagus
Pear-Grated Cheese Salad
White Cake

8
Pear Juice
French Toast, Honey
•
Beef Stew With Carrots,
Onions, Celery
Boiled Potatoes
Citrus Salad
Apple Betty
•
Tomato-Beef Bouillon
Cubed Steaks
Mashed Potatoes
Fresh Frozen Green Beans
Lettuce Salad With
French Dressing
Gelatin Whip

9
Prunes
Soft Cooked Eggs
•
Roast Pork Loin With
Dressing and Applesauce
Browned Potatoes
Buttered Broccoli
Pineapple Salad
Orange Sherbet
•
Cream of Spinach Soup
Veal à la King on
Biscuits
Harvard Beets
Tossed Green Salad
Royal Anne Cherries

10
Orange Juice
Omelet
•
Chop Suey
Boiled Rice
Celery Cabbage Salad
Custard Pudding
•
Beef Broth With Barley
Lamb Chops
Baked Potatoes
Mixed Vegetables
Orange-Avocado Salad,
Celery Seed Dressing
Purple Plums, Sugar
Wafers

11
Pineapple Juice
Scrambled Eggs
•
Salmon Steaks With
Tartare Sauce
Parslied Potatoes
Spinach With Egg Slice
Fruit Salad
Jelly Roll
•
Cream of Potato Soup
With Grated Cheese
Pimiento Peas
Stuffed Tomato Salad
Fresh Grapes

12
Grapefruit Juice
Blueberry Muffins
•
Liver With Onions
Anna Potatoes
Diced Carrots
Asparagus Salad
Chocola[illegible] Pudding
•
V-8 Juice
Veal Loaf With Brown
Sauce
Parisian Potatoes
Celery Sticks
Pineapple Salad
Prune Whip

13
Orange Halves
Eggs With Chipped Ham
•
Beef Roast With Gravy
Riced Potatoes
Buttered Swiss Chard
Zucchini
Frozen Fruit With
Oatmeal Cookies
•
Cream of Tomato Soup
With Croutons
Baked Potatoes
Cottage Cheese and
Endive Salad
Pineapple Upside-Down
Cake

14
Stewed Raisins
Soft Cooked Eggs
•
Braised Lamb With Mint
Sauce
Mashed Potatoes
Buttered Green Beans
Asparagus-Tomato Salad
Vanilla Pudding
•
Salisbury Steaks, Ketchup
Potatoes on Half Shell
Lettuce Salad
Deep Dish Apple Pie

15
Fresh Grapes
Bacon
•
Kidney Stew With Biscuit
Topping
Celery Cabbage Salad
Chocolate Custard
•
Cold Roast Beef
Sliced Tomatoes
Potato Chips
Cherry Cobbler

16
Tangerine Juice
Omelet With Jelly
•
Chicken With Noodles
Diced Beets
Coleslaw With Pineapple
Orange Sherbet
•
Split Pea Soup
Corned Beef Hash Baked
With Ketchup
Shredded Lettuce Salad,
Thousand Island Dressing
Sliced Peaches With
Macaroons

17
Apricot Juice
Soft Cooked Eggs
•
Baked Ham, Raisin Sauce
Parslied Potatoes
Glazed Carrots
Princess Salad
Ambrosia
•
Chicken Broth
Cheese and Rice Soufflé
With Spanish Sauce
Buttered Green Beans
Stuffed Prune Salad
Ice Cream

18
French Applesauce
Bacon
•
Carrot Juice
Tuna and Mushroom
Casserole
Minted Peas
Peach and Cottage Cheese
Salad
Gingerbread
•
Beef Heart With Dressing,
Gravy
Glazed Parsnips
Lettuce With Thousand
Island Dressing
Whole Apricots

19
Stewed Prunes
Poached Eggs
•
Roast Turkey With
Dressing, Gravy
Duchess Potatoes
Green Salad
Fruit Cup
•
Oven Smothered Liver
Lyonnaise Potatoes
Baked Squash
Olive-Tomato Salad
Butterscotch Pudding

20
Orange Juice
Blueberry Muffins
•
Swiss Steaks
Mashed Potatoes
Green Beans
Stuffed Celery
Ice Cream Sundae
•
Smoked Tongue With
Caper Sauce
Parslied Potatoes
Tomato, Celery and
Lettuce Salad
Bread Pudding With
Chocolate Sauce

21
Grapefruit Juice
Bacon
•
Fruit Juice Cocktail
Lamb Stew
Tossed Green Salad
Cherry Cobbler
•
V-8 Juice
Chicken Pot Pie
Harvard Beets
Under-the-Sea Salad
(Gelatin)
Apple Custard

22
Orange Halves
Ham
•
Prune Juice
Veal Birds
Buttered Asparagus
Tomato Salad
Chocolate Cake
•
Scotch Broth
Creamed Turkey on Toast
Buttered Broccoli
Stuffed Tomato Salad
Fruited Ice

23
Cherries
Soft Cooked Eggs
•
Fillet of Haddock
Lyonnaise Potatoes
Baked Squash
Citrus Salad
Custard
•
Broth
Meat Loaf With Tomato
Sauce
Creamed Peas
Vegetable Salad
Ribbon Pudding

24
Bananas
Scrambled Eggs
•
Tomato Juice
Creamed Sweetbreads
Browned Potatoes
Buttered Green Beans
Cupcake Surprise
•
Chicken-Noodle Soup
Hamburger Patties Baked
in Bacon Curls
Glazed Parsnips
Stuffed Celery
Orange Cake

25
Baked Apples
Scrambled Eggs
•
Vegetable Soup
Fish Hash
Grilled Tomatoes
Pineapple Salad
Lemon Pudding
•
Salmon Loaf
Buttered Asparagus
Carrot-Raisin Salad
Apricot Crisp

26
Broiled Grapefruit Halves
Bacon
•
Cubed Steaks
Whipped Potatoes
Spinach With Egg Slice
Pear and Apricot Salad
Ice Cream
•
Split Pea Soup
Cheese Soufflé
Oven Breaded Eggplant
Green Salad
Gelatin With Mixed Fruit

27
Rhubarb
Three Minute Eggs
•
Clear Consommé
Baked Ham With Citrus
Sauce
Glazed Sweet Potatoes
Swiss Chard
Apricot Whip
•
Rolled Lamb With
Dressing
Baked Squash
Green Beans Creole
Stuffed Celery
Sherbet With Cookies

28
Mixed Fruit Juices
Omelet
•
Vegetable Juice
Meat Loaf
Creamed Pimiento
Potatoes
Lettuce Salad
Baked Custard
•
Barley Soup
Roast Duck
Escalloped Sweet Potatoes
and Apples
Endive and Orange Salad
White Cupcake

29
Apricots
Eggs in Shell
•
Oven Smothered Rabbit
Baked Carrots
Creamed Peas
Grapefruit-Avocado Salad
Chocolate Pudding
•
Lamb Chops
Escalloped Potatoes
Buttered Asparagus
Autumn Fruit Salad
Snow Pudding With
Custard Sauce

30
Grape Juice
Scrambled Eggs
•
Loin Roast of Pork,
Cranberry Sauce
Mashed Potatoes
Escalloped Celery
Tossed Green Salad
Strawberry Bavarian
Cream
•
Creamed Shrimps on
Noodles
Carrot Ring With Peas
Apples Stuffed With
Mincemeat

31 Orange Juice, Bacon • Roast Stuffed Chicken, Giblet Gravy, Whipped Potatoes, Buttered Broccoli, Apple-Nut-Celery Salad, Pumpkin Custard • Ham With Escalloped Potatoes, Prune-Cottage Cheese Salad With Lemon Gelatin Squares, Chocolate Jack-O'-Lantern Cake

Ready-to-eat or cooked cereals are offered on all breakfast menus.

PLANT OPERATION & MAINTENANCE

Stains Don't "Set" *on water repellent fabrics*

H. H. LAMPMAN

PERHAPS the greatest advantages of the use of water repellents in treating fabrics is their ability to make cloth shed water and all the stains carried by water. It has been the experience of some hospitals that the total number of uniforms laundered each week for nurses has been substantially reduced by the application of water repellents in the laundry process.

Most clothing is soiled by dirt carried in the medium of moisture. The effect of underarm sweating on clothes has been reduced. And best of all, uniforms, patients' linen and doctors' gowns all launder much more easily, since the dirt and stains are not *in* but *on* the fabric. Water soluble stains and soil never are given the chance to "set" in the fibers of a garment.

Thus the use of water repellents has resulted in fabric conservation. Garments which formerly wore out quickly because of the necessity for stain removal through laundering now last, according to some claims, twice as long. Nurses' or interns' apparel, which formerly had an average life of twelve months, is reported to last two years.

Wipes Away Tomato Juice

Other spectacular results have been cited by observers investigating the claims of firms making water repellents. A nurse who inadvertently knocks a glass of tomato juice over at the breakfast table finds she can wipe away all trace of the crimson, pulpy liquid from both her uniform and the table linen because both have been treated with a water repellent.

The author is manager of the publicity and editorial department, American Institute of Laundering, Joliet, Ill.

A research worker watched the test of a water repellent in which the application was made to mosquito netting. The mosquito net obviously was functionally unchanged by the addition of the water repellent. But when the netting was placed on a ring and water was poured into the cup of the circle, it failed to run through. The water repellent had the effect of increasing the surface tension of the water so that the netting refused to pass the liquid, yet the porousness of the netting had not been impaired in the slightest.

Companies producing water repellents have recommended their use in scores of ways. In a modern hospital, almost everything washed in the hospital laundry might be improved by the treatment. Curtains, shower curtains, bedspreads and table linens, as well as uniforms and gowns, all could be made to wear better, last longer and look better if manufacturers' claims for water repellents are even partly true. And at the present development of water repellent application, there seems to be no reason to doubt most claims.

How is water repellent treatment given as part of the laundry process?

Water repellent compounds generally may be divided into four groups: (1) fatty and resinous insoluble substances which are applied mechanically, as in the production of oiled silk or rubberized fabrics; (2) metallic soaps applied in conjunction with a wax emulsion; (3) synthetic resin; (4) a finish in which the fibers themselves are chemically changed.

Of these, the hospital laundry operator need concern himself only with the metallic soaps in wax emulsions because they are commonly and easily applied in the laundry process. They require no additional or new equipment. Power laundries can treat garments for as little as a penny a piece, according to best estimates.

The wax emulsion type of water repellent is a stable mixture of material normally insoluble in water. But with the emulsifying agent, the wax particles are suspended, much in the same way as the oil of mayonnaise is suspended in a water solution, with egg white serving as the emulsifying agent. Added to this emulsion is the metallic salt. The compound ready for use is blended and colloidized. Most water repellents employ aluminum formate or aluminum acetate as the metallic salt.

Helps Fabric Shed Water

The function of the wax emulsion is obvious. It helps the fabric shed water when fibers are coated with its finely dispersed particles. Somewhat more obscure is the reaction of the metallic salts. Actually, the metallic salts act as an agent in several ways to improve the water repellent qualities of the solution. They coat the fibers like the wax emulsion and are themselves hydrophobic or water repellent. The end products of the metallic salt reaction help form a film on the fiber and do not penetrate as deeply as does the wax. This film adds to the water shedding qualities of the treated article.

Some authorities have recommended the use of aluminum formate compounds rather than aluminum acetate because the latter substance tends to give off a sour odor when cloth treated with it is ironed. But the textile department of the Amer-

ican Institute of Laundering suggests that hospitals interested in water repellents explore the market and test sample compounds in their own laundries. If such tests are made according to manufacturers' directions, the results should be perfectly satisfactory.

There are several methods for treating clothes for water repellency in laundries. In a large hospital, where the flow of uniforms, sheets and linens is uninterrupted throughout the work week, it would perhaps be most economical to add the water repellent compound to the final rinse. Several hundred pounds of washables could be treated this way in the single operation. The goods thus treated in the final bath of the regular washing cycle would emerge not only sterile and sparklingly clean but proof to a great extent against the soil and stains of ordinary use.

It might be well to reiterate that such treatment makes articles proof against water soluble stains only; alcohol solutions and chemicals in other vehicles may stain the fabric as quickly and as permanently as though it had not been treated with any compound at all.

Other manufacturers may recommend that the water repellent compound be made up in a standing bath in which articles can be immersed by hand. Or the bath may be applied in a regular wash wheel in which the treated articles are subject to agitation. Another method, and perhaps the least useful to laundries, is the application of the compound by a spray gun. It is unlikely that the application by spray gun would be practical for hospital use.

Perhaps one of the easiest ways to treat a nurse's or intern's uniform with a water repellent compound is the addition of the repellent to the starch used in the garment. Not only would such a finished garment be proof to some extent against stains, but manufacturers say that it would remain fresh looking longer. To nurses who have always fought bulges and wrinkles and that "slept-in" look in their uniforms, such "wilt proofing" would be valuable.

Other types of water repellents are not discussed in this article because they need specialized equipment not found in hospital laundries. The wax emulsion-metallic salt repellents are readily available and easily applied. The fact that they must be renewed in each laundering is, from the standpoint of the hospital administrator, a virtue.

To prevent any misunderstanding, it might be wise to point out the difference between water repellents and waterproofing compounds. Repellents have been covered in the foregoing paragraphs and their application and use should be clearly understood. Waterproofing compounds, on the other hand, actually prevent the passage of water when applied to the surface of textiles. They form a watertight, impervious surface on the face of the cloth. Their application would not be acceptable in hospitals where the porousness of fabrics is so necessary.

Hospital administrators and boards also might do well, in consideration of water repellents, to weigh the benefits and drawbacks of their application to certain articles. Obviously, the operating gown would serve doctors better if it resisted blood staining. But should bed sheets be absorbent and take up moisture or should they be treated for water repellency? Treated table linen, while repellent to water and water-borne substances, does not soak up the ordinary moisture which congeals on cold water glasses. And if something is upset on treated table linen, it promptly flows to the table edge—and probably into someone's lap. If the person is a nurse and if she is wearing a uniform which also has been treated, then the course of the coffee, tomato juice or whatever it might be will continue to the floor. But to the wearer of untreated garments, the water repellency of the table covering may be an unfortunate discovery.

Perhaps worthy of mention are recent attempts to combine water repellent compounds in their application with germicidal agents. If these experiments are successful, and there seems no reason why they could not be conducted in self interest by any large hospital, then not only could an operating gown be made clean, sterile, stain resistant and water repellent, but it would finally be possessed of germicidal power of its own. Such a development might be considered a valuable forward step in operating room management. Part of the worry of doctors over the sterilization of their operating gowns would be eliminated if the gowns themselves had germicidal properties.

Watch These Hazards

HERE is a list of electrical hazards that should be posted where it will serve as a reminder to the unwary employe.

1. Any stepdown transformer should be carefully isolated from all but qualified persons who know their way around this type of equipment.

2. All switches should be enclosed. Equipment of 550 volts is always hazardous and 200 or even 110 volts can kill or injure a person in poor health.

3. Portable lights should have heavily insulated cords and the moment a cord becomes worn it should be replaced. It is advisable to use sockets that are keyless, with an insulating enclosure and handle.

4. Motors, generators, transformers and switchboards should be enclosed or protected if they are within 8 feet of floor or working area.

5. Circuits of from 25 to 150 volts to ground should be permanently grounded, except two-wire direct current systems and circuits exposed to leakage or induction from higher voltages.

6. Motor, generator, transformer and switch frames and cases should be grounded if they are operating at more than 150 volts to ground; if they are exposed to inflammable gas or explosives, or if they are within reach of other exposed grounded surfaces.

7. Working space next to live parts, carrying more than 150 volts to ground, should be at least 30 inches; not more than 150 volts, 18 inches. Space between live parts (more than 150 volts) on one side and live or grounded parts on the other side should be 48 inches; not more than 150 volts, 30 inches.—ERNEST W. FAIR, *Bristow, Okla.*

WATROUS *SILENT-ACTION* Eliminates Flush Valve Noise Without the Use of Screens

. . . .

. . . Another

of the many Watrous Points of Superiority

- Water Saver Adjustment
- Self-Cleansing By-Pass
- Single-Step-Servicing
- Self-Tightening Handle Packing
- ✓ Screenless Silent-Action
- Sturdy Brass and Bronze Construction

THE growing preference for silent-action in flush valves has resulted in the development of many methods of silencing. The difficulty with earlier methods, using some form of screen, shot, muffler, or similar elements which invariably become clogged, was that the flush valves either did not remain quiet—or the silencing elements had to be cleaned or replaced all too frequently.

Recognizing these shortcomings, the manufacturers of Watrous Flush Valves developed a remarkably efficient dispersion silencing element which silences the flow of water through the use of a large number of corrugations, as described at right.

Watrous *Silent-Action* Flush Valves not only eliminate all objectionable flush valve noise but they assure silent operation that *STAYS* silent. These valves have no parts requiring frequent replacement, cleaning or adjustment.

Before you select flush valves for buildings where noise reduction is desirable, get complete information on Watrous *Silent-Action* Flush Valves.

THE IMPERIAL BRASS MFG. COMPANY
1244 W. Harrison St., Chicago 7, Ill.

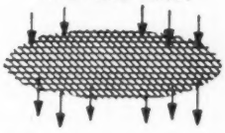
Silencing Flush Valves

THE WATROUS WAY

The new method of silencing used in Watrous SILENT-ACTION Flush Valves is to pass the water between two surfaces having a large number of corrugations or roughened surfaces which act as "brakes" that silently arrest the surge of water to the valve and eliminate turbulence.

Note there is nothing in this unit which requires replacement and there is ample space for dirt and scale to pass through. As a result, silent operation stays silent and there is no need for frequent adjustment or renewal of parts.

THE OLD WAY



The old method of silencing flush valves is to pass part or all of the water going to the valve through one or more screens. (Perforated discs or shot pellets also used). The trouble with this method—as the screen on your kitchen faucet will quickly show you—is that screens become clogged and must be cleaned or replaced at frequent intervals.

Also, clogging makes necessary frequent adjustment of the shut-off to keep the valve working properly.

For complete information on Watrous Flush Valves see Sweet's Catalog or write for Catalog No. 448-A. Also ask for Bulletin No. 477 giving a summary of "Architects' Views on Flush Valve Applications."

THEY PAY FOR THEMSELVES IN THE WATER THEY SAVE

. . . . . .

Watrous Flush Valves

See here, Mr. Architect,

and you, too, Mr. Administrator

EMILY C. DEMING
Executive Housekeeper
Butterworth Hospital
Grand Rapids, Mich.

THE housekeeper has a stake in that new building or addition. It is, after all, her responsibility to see that it is properly maintained with the greatest efficiency and at the least cost. It is her maids whose excursions in search of supplies and linens require a dozen trips daily, 11 of which would probably be rendered unnecessary if their working areas were well laid out, with all the tools of their trade neatly and conveniently arranged.

So it is that before the building is constructed, even before it reaches the blueprint stage, there should be consultations between the administrator and architect on the one hand and the executive housekeeper on the other to ensure a building that is so well planned that the maintenance of it will require the minimum of effort, expense and exhaustion.

The ideas and suggestions set forth here are aimed at achieving that goal. Some of them may seem of minor importance but they can make the difference between a smoothly running machine that serves the best interests of patient and hospital and "just another housekeeping department."

I am sure that many executive housekeepers will echo my own prayer for:

1. **A basic color harmony plan** that will provide a variety of interesting, restful or stimulating combinations within its range.

2. **Standardization of window sizes** within given areas or specific groups of rooms or pavilions so that curtain rods, shades, venetian blinds, curtains, draperies and screens are interchangeable, allowing a minimum number of sizes necessary in stock to provide for repair, replacement or unit cleaning. The window itself is of primary importance. Count the time, and thus the cost, of washing before choosing the type that is to be installed.

3. **Door catches** that catch without tripping the unwary.

4. **Baths** that provide space for the patient's robe, gown, towels, bath mats and necessary medical supplies. Adequate space is needed, too, at every bedside, especially in ward and multiple rooms with no bath, to hang towels and face cloths.

5. **A planned space for flowers** that will make them a part of the room decoration, not just another nuisance to be moved from bedside table to chest to desk and back to bedside.

6. **Built-in furniture.** Increased use of these functional units in our homes, with excellent results, should cause us to give some consideration to the possibility of a built-in unit at least for the private and semiprivate rooms. Such a unit could be compact, requiring less space than the present dresser and desk or table that are usually found—and it couldn't be moved at every passing whim to be scratched and banged by doors.

In addition, the built-in unit should provide one drawer for writing materials, two or three small drawers and one larger one for the patient's belongings, a shelf or rack for magazines or books. It could have a copper lined well for plants, to guard against the water marks we all dread, and could have several shelves at interesting intervals above it for small plants or bouquets.

A good mirror, either open or with a closing frame, would be necessary. The unit top should be of a size and height to permit letter writing or tray service for patient or guests. The base should provide leg space for comfort in these uses.

7. **Suitcase racks.** Every room should provide space for the usual medium sized suitcase, either in the clothes closet or on a sliding shelf incorporated into the built-in unit.

8. **Lights, fixtures and brackets,** of any and all kinds, that are easy to remove, clean and replace. Tricky little jobs may be simple for the engineer or architect to fathom and appealing to the women's board committee that makes the selection, but remember always that the housekeeper must maintain this new unit with the same, or even less efficient, employes, growing ever scarcer in a highly competitive market; employes who, in many cases, cannot read, write or sometimes even so much as tell time! The extra few minutes each such operation adds to the housekeeping schedule can reach an appalling cumulative total in dollars and cents over the years.

One new window installation with automatic inside roller screens baffles even the orderly and nursing staff as much as it intrigues the patients and their guests. In consequence, it is everlastingly jammed or out of order one way or another.

9. **Utility rooms and floor sterilizer units** that are selected and installed with the "no drip" feature of paramount importance; elimination of some of the forest of legs on the floor, and the measure of the length of a maid's arm, even using a 36 inch brush, kept constantly in mind.

10. **Public restrooms** that have faucets with automatic release shut-off; built-in, *never* attached, soap dispensers, towel and toilet paper holders and waste containers. A small shelf for purses and other impedimenta in each toilet stall could easily

Here's OUR Answer to the SOAP SHORTAGE!

Today's soap shortage is serious. But here's a new product—UNIKO—that's not only a real soap saver but a big washing improvement as well. Although on the market only a few months, already enthusiastic reports are coming in from users. Soap savings of 30% to 35% are common . . . in some cases savings run as high as 50%. But, more than that, users report Uniko gives far better breaksuds cleaning.

Uniko cleans automatically, requires no change in washing formula

Uniko is a complete detergent—replaces both soap and alkali in the break. Simply dip it dry from the barrel—1½ lbs. Uniko to 100 lbs. of washing—toss the Uniko in the washwheel. No mixing . . . no need to check pH's or bother with titration. Just start the wheel and Uniko does the rest. Here's the easy, modern way of making your breaksuds. Even unskilled help can handle a Uniko break.

There's still another big advantage in using Uniko. Its specially balanced formula enables Uniko to do an amazingly thorough washing job on embedded dirt and stains. It stands up against loose soil and excess acidity. Unlike soap, Uniko stays in suspension—you don't have to worry about Uniko precipitating a grey, unrinsible layer on the fabric. Clothes come from the break cleaner, *so less soap is needed in subsequentsudsing operations.*

Uniko is more than a new product . . . more than a real soap saver . . . it's a new, better, money-saving way of handling the breaksuds. For more information, ask our representative, or write the nearest Kohnstamm branch office.

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LARGEST MANUFACTURERS OF LAUNDRY SUPPLIES IN THE WORLD

be made part of the door. An unbreakable makeup surface under the mirrors and walls that cannot be stained with lipstick and rouge by the wags who are amused by gay jottings are *musts*.

11. Beds that are capable of conversion to crib, fracture, cardiac and eye service would mean much saving in wear and tear resulting from constant shifting of furniture. Done hurriedly, often at odd hours and unsupervised, one moving can cause more damage than many months of use.

12. Adequate, properly placed lighting. The bed lamp that scorches the bed but sends no ray over the raised back rest is of little use to the patient.

13. Adequate ice delivery that requires a minimum of time and traffic. Decentralized freezing, as flake ice, at the point of use seems to be the best solution.

14. Chutes for the delivery of soiled linens to the proper level for laundry pickup, so arranged that soiled linen hampers fall into the pickup carts and can be rolled to the sorting room with no additional handling.

15. Storage and work space. And in heaven's name make it adequate for the supplies that must be stored and the work that must be done. A planned maid's closet, not a hole in the wall; depressed floor drains, not hoppers that require the maid to lift a heavy pailful of water above her waist; a few shelves; a drawer; racks with hooks for all brush tools, these are essential. And they will all go into the same space that is now allotted, and make for tidy closets, clean, well kept equipment, a maid with some pride in her working home base. They will save time, too.

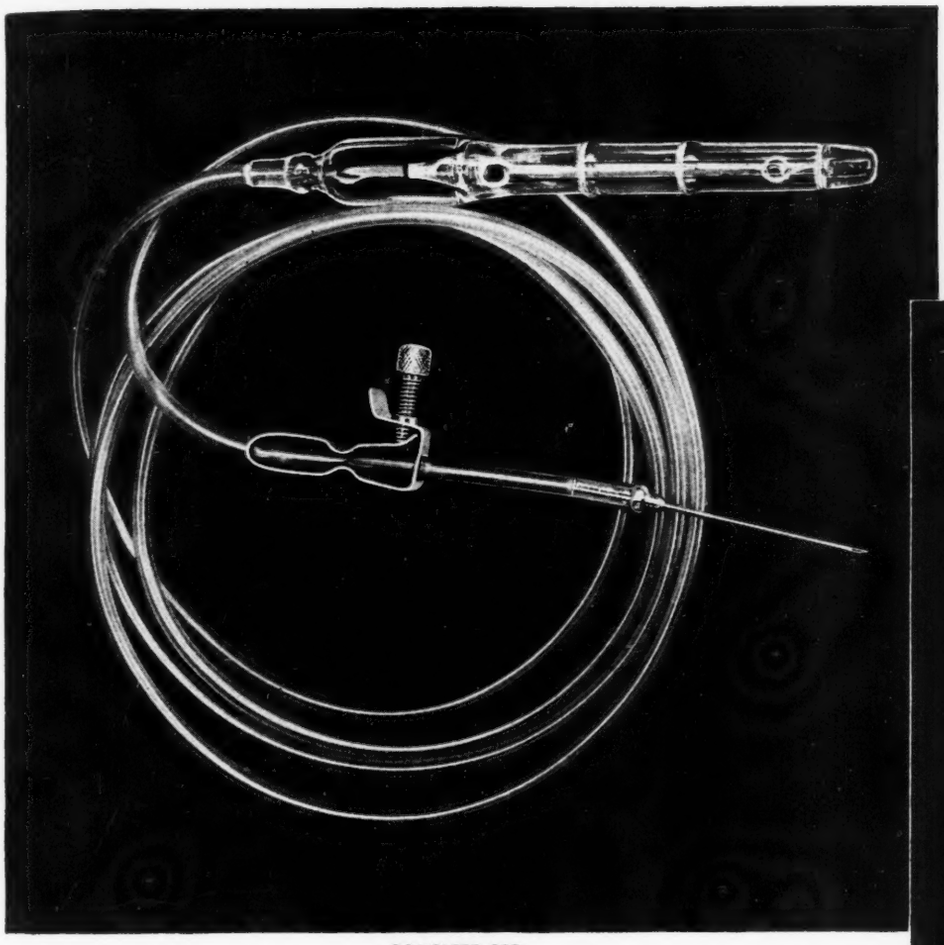
Room should be allotted for the mending and manufacture of linens, for storage of linen supplies and for the sewing and marking machines that will be used.

Finally, while we are on the subject, storage space for all types of housekeeping supplies is necessary, and vitally necessary are space and equipment for washing and repairing blinds, shades, rugs and furniture. Compact, planned units, utilizing all space from floor to ceiling, graduated from the items in daily use to reserve blinds, shades, footstools and cushions stored on the upper levels, would mean greater efficiency, savings resulting from proper care and instant availability of every item.

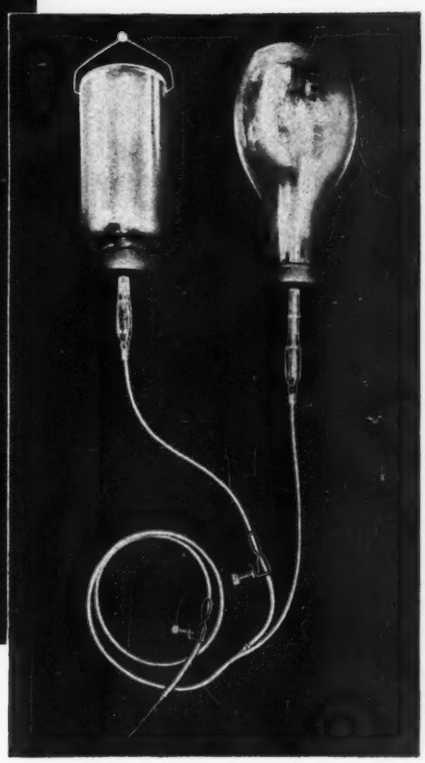
Any housekeeper could go on and on with this list but if my beginning inspires even a few administrators, architects and consultants to confer seriously with their housekeepers about the new buildings, there will be rich rewards to them in future hours saved in maintaining a high level of housekeeping efficiency—and every hour must be purchased with the patient's dollar.

Paging Philadelphia-Bound Executive Housekeepers!

The Philadelphia chapter of the N. E. H. A. will have a reception booth at the American Hospital Association convention and issues a cordial invitation to housekeepers to drop in for a visit between the sessions



COMPLETE SET



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Illustrating simplicity and time-saving convenience of administering supplementary medication by puncturing of expendable tubing.

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Especially designed with solid, tapered distal end through which the lumen is extended to a flush surface. Offers greater safety as there is not recessed area to make cleaning difficult. Unexcelled for use with Fenwal expendable tubing.

ADAPTER (for standard needles)

Made of Pyrex Brand glass with precision ground Luer tip, this adapter provides a ready means of using Fenwal expendable tubing with standard needles.

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Designed to facilitate the use of Fenwal expendable tubing in conjunction with commercially prepared solution containers and non-Fenwal tube and needle sets.

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FENWAL Single Vent Tube with Drip (Cs. of 48)	W9016
FENWAL Special Needle (Bx. of 12)	W9056
FENWAL Flow-Control Clamp (Cs. of 48)	W9054
FENWAL Adapters (Cs. of 48)	W9031

NEWS DIGEST

President Objects to, but Signs, S. 191

Providing $3,000,000 of federal funds to aid hospital surveys and $75,000,000 a year for five years for authorized hospital construction, S. 191, the Hospital Survey and Construction Act, was signed by President Truman August 13.

In signing the act, the President objected publicly to two of its features: (1) the fact that a hospital advisory council may veto certain actions taken by the surgeon general of the U. S. Public Health Service, who will be the chief administrative officer of the program, and (2) the provision that state agencies whose plans are disapproved by the responsible federal administrator may appeal to the federal courts.

Polio Outbreak Worst Since 1916

With more than 9000 cases reported by the middle of last month, the nation is having its worst poliomyelitis year since 1916. Cases are nearly 40 per cent higher than in 1944, the second worst year. Severest outbreaks are in the Middle West, especially Minnesota and Illinois, and in the South. Several hundred nurses have been recruited for polio service from the Red Cross disaster reserve. Their services are paid for by the National Foundation for Infantile Paralysis.

Health Co-ops Co-op

Delegates from 26 organizations providing group medical service to 200,000 members met at Two Harbors, Minn., August 18 to form the Cooperative Health Federation of America. Object: To pool the strength of all medical service groups in which consumers, or patients, participate, and to oppose the "virtual monopoly of medical service plans" by medical societies.

Among the directors elected were: Dr. Dean Clark, Health Insurance Plans of Greater New York; Nelson Cruikshank, A.F. of L.; James Carey, C.I.O.; Harry C. Culbreth, Farm Bureau Federation; Dr. John V. Lawrence, Labor Health Institute, St. Louis, and Gladys Edwards, National Farmers Union.

Doctors Observe Insulin Birthday

Physicians from the United States, Canada, Great Britain, Denmark and Argentina will take part in observance of the twenty-fifth anniversary of the discovery of insulin at the University of Toronto September 16, in connection with the annual meeting of the American Diabetic Association.

A week later, an augmented group of diabetes specialists will meet in Indianapolis for an international clinic sponsored by Eli Lilly and Company. Featured on this program will be Dr. Charles H. Best of Toronto, who with Sir Frederick Banting was co-discoverer of insulin.

Two Universities Offer H.A. Study

Graduate courses in hospital administration will be offered for the first time this fall at the University of Minnesota, Minneapolis, and Washington University, St. Louis. Both courses are supported by grants from the Kellogg Foundation. Applicants for both courses must have a bachelor's degree from an acceptable college. The courses are of approximately two years' duration, including an administrative internship.

At Minnesota, the program is under the supervision of a committee including deans of the schools of business administration and public health and the superintendent of university hospitals. At Washington, instruction will be supervised by the school of medicine, the school of business and public administration and Barnes Hospital.

Record Librarians to Get Training

In-service training for medical record librarians will be offered at 24 hospitals throughout the country under a program sponsored jointly by the American Association of Medical Record Librarians, the A.M.A., A.H.A. and A.C.S., under a grant from the National Foundation for Infantile Paralysis. The course will be open to present or former employes of medical record departments of registered hospitals. It will cover such subjects as nomenclature, medical terminology, case record analysis, hospital statistics and staff relationships.

Labor Leaders Talk to Personnel Group

Labor relations claimed a major share of attention at the Institute on Personnel Management conducted by the A.H.A. and the University of Chicago the week of July 29 at the Drake Hotel in Chicago.

Unionization of hospital workers cannot be stopped, Arthur T. Hare, secretary of the Hospital and Institutional Workers Union, San Francisco local, told the institute. He predicted that all professional workers, including graduate staff nurses, would organize into unions.

Another speaker at the institute was W. L. McFettridge, president of the Building Service Employes International Union. Enrollment at the institute totaled 120.

Insurance Executives Praise Blue Cross

High praise for Blue Cross was an unusual feature of the National Association of Insurance Commissioners' meeting in Washington last month. The significance of Blue Cross to public health cannot be overlooked, a special committee on group hospitalization and medical service reported. "The high proportion of income going directly into payment of hospital bills and the low expense ratio indicate that nonprofit plans can do the job which has been set out for them," the committee stated. "In addition, the prudence which most of the plans have exercised in the establishment of reserves, and their industry in enrolling high percentages of the population, makes this one of the most significant nongovernmental health insurance programs in the world."

Bureau Launches Nursing Study

A detailed survey planned to define the economic status of nurses has been undertaken by the U. S. Bureau of Labor Statistics on behalf of the National Nursing Council. The survey will cover about 40,000 nurses with a questionnaire seeking information about salaries, hours, working conditions and job attitudes, the council explains. In addition, interviews with a smaller sampling of nurses will try to determine why nurses are leaving their jobs for other fields and moving around from job to job within the profession.

Crash Victim Designs Bed

A new hospital bed designed to relieve discomfort for fracture patients suffering from spinal injuries was designed by Howard Hughes, airplane manufacturer, during his stay in Good Samaritan Hospital, Los Angeles, following the plane crash which nearly cost him his life July 7.

The new bed features six adjustable screw jacks supporting separate, square sections of mattress running down the center of the bed under the patient's spine. By adjusting the jacks with cranks at the side of the bed, attendants can bring the spine to any desired curvature.

Vane Hoge Heads New Division to Direct State Aid Under S. 191

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Hospital Survey and Construction Act, S. 191, became law with the President's signature August 13. The bill as passed contains essentially the provisions reported by the House. All federal funds for surveys, planning and construction costs must be matched by nonfederal funds two to one.

To direct this comprehensive system of federal aid to the states, the surgeon general has set up a new division of hospital facilities in the Public Health Service. It is headed by Dr. Vane M. Hoge, senior surgeon, U.S.P.H.S., as medical director.

Public and other general, tuberculosis, mental and chronic disease nonprofit hospitals may be constructed under the program.

Related facilities include laboratories, outpatient departments, nurses' homes and training facilities, and central service facilities operated in connection with hospitals. Not included is any hospital furnishing primarily domiciliary care. Health centers are also included in the construction program.

The surgeon general of the U. S. Public Health Service, with the approval of the Federal Hospital Council and the Federal Security Administrator, will establish general standards under which each state will develop its own program of hospital and health center construction. The council will consist of eight members, four to represent the professional field, four, the consumer.

Some Funds Appropriated

No part of the $75,000,000 construction fund has yet been appropriated. Already set apart by Congress, however, are two million of the three million dollars authorized for the preliminary steps. In any state, the survey must be made and the state plan developed and approved before federal funds will be granted for construction. Any state may initiate action by submitting a request to the surgeon general for funds to carry out a survey of existing hospitals and to prepare a master construction plan for such facilities necessary to provide adequate care for all the people.

In making the request, the state must designate a single state agency to carry out the survey and planning. It must also appoint a properly qualified advisory council composed of producers and consumers of medical services to consult with the state agency. Funds for the survey will be allocated on the basis of state population. The state must be ready with its matching funds—two dollars for every one it receives.

Once the funds are provided for, the state will make an inventory of its existing hospitals and related facilities. On the basis of this survey, a statewide plan will then be mapped. Where need for new hospitals and other health facilities is indicated, their relative urgency of need must be determined. The plan must conform with the regulations set up by the surgeon general. It must meet requirements as to lack of discrimination on account of race, creed or color, and for furnishing needed hospital services to persons unable to pay. Applications must be channeled through the designated state agency.

Applications for individual construction projects can be considered only after the state plan has been approved by the surgeon general. An application must be in conformity with the state plan and high in the list of priority needs. Nonfederal funds must be available for two thirds of the construction costs. Evidence must accompany the request that financial support is adequate for the maintenance and operation of the hospital after it is built.

This type of grants-in-aid program sets a precedent for federal grants-in-aid. Federal responsibility ceases when the hospital is built. From this point on, the state or community assumes full responsibility for the maintenance and operation of the institution.

Construction allotments to individual states will vary in amount. The distribution of funds will be in accordance with a formula which employs two factors—population and per capita income. The formula is weighted so that states with a lower per capita income and with greater need for hospital facilities will get relatively more funds per capita than do the wealthier states. Nevertheless, all funds must be matched on the two to one basis.

A preliminary list of funds allocated by the states appears on page 142.

Surplus Items for Sale

WASHINGTON, D. C. — Close to $100,000,000 worth (in original cost) of surplus valves and pipe fittings were offered all classes of purchasers, including priority claimants, in a national sales program beginning August 1. The inventory included commercial, industrial, navy, maritime and other special types of valves and pipe fittings. The navy types include many items that are adapted to industrial and commercial piping applications. The valves, made of steel, bronze and cast iron, include a full range of pressure ratings.

Army Issues Recall to 1000 Nurse Officers to Serve Army Patients

By EVA ADAMS CROSS

WASHINGTON, D. C. — The medical department of the army has called on 1000 former army nurse corps officers to return to active duty on a volunteer basis, it was announced here July 30. Nurses who come back into service will be given their choice of two categories. They may don their uniforms again to serve (1) until relieved at the convenience of the government or (2) for two years. The recall is necessary to ensure the best possible care of some 90,000 patients still in army hospitals throughout the world.

Other corps in the medical department which have been authorized recall quotas are medical corps, 100; dental corps, 100; sanitary corps, 50; veterinary corps, 25, and dietitians, 50. In general, all officers who return to active duty must qualify for general duty and be available for overseas duty.

Already, 1500 former Army nurses have notified the War Department they are ready to trade civilian life for further military duty. The 1000 just called are needed in addition to these. They will not be considered if they are married or have dependents under 14 years.

Interim Commission Runs World Health Group

An interim commission will run the World Health Organization pending ratification by member nations of the constitution drawn up by delegates meeting in New York last month, W.H.O. announced following the meeting. Dr. Andrija Stampar of Yugoslavia was named chairman of the interim commission, whose vice chairmen include representatives from China, Egypt and Mexico.

A commission committee on administration and finance has approved a budget estimate of $1,000,000 for 1947 to carry out the program for the initial year, which includes establishment of an eastern division at Singapore to obtain epidemiological information.

Lauds Army Medical Branch

WASHINGTON, D. C. — General of the Army Dwight D. Eisenhower paid special tribute to the doctors, nurses, technicians and enlisted personnel of the army's medical branch in a commemorative program held July 27 at Walter Reed Hospital in honor of the 171st anniversary of the medical department. He declared that army medical skill was one of the greatest factors in the defeat of Germany and Japan.

Hospital Workers Will Be Organized, Union Official Tells Personnel Group

Strikes against hospitals must not be called, and unions of hospital workers should submit to compulsory arbitration whenever necessary to protect patients, a union representative told members of the Institute on Personnel Management conducted by the American Hospital Association in Chicago last month.

"The public interest is too much at stake to allow strikes of hospital workers," declared Arthur T. Hare, secretary of San Francisco local 250, Hospital and Institutional Workers Union (A.F. of L.). The vast majority of differences between management and labor in hospitals can be settled by peaceful negotiation, Hare insisted. When negotiations break down, both sides must submit to arbitration, he said, so that there need be no fear of strikes.

A former hospital employe who has been an active union worker and officer since 1932, Hare told hospitals they would have to start facing the facts of life concerning labor relations. "Trade unionization of workers in the hospital field cannot be stopped," he said flatly. "How can you expect to hire any but the lowest grade workers unless you are meeting the wages and working conditions prevailing in institutions, hotels and buildings where unions exist?" he asked. Before long, he predicted, professional as well as building employes of hospitals would be organized into unions. This includes graduate staff nurses.

Unions definitely favor prepayment hospitalization and medical care plans for workers, Hare said. In fact, he continued, many unions already are including availability of such plans among the conditions of employment specified in labor-management contracts, and this practice will probably become more widespread as time goes on.

Blue Cross has done a great job for wage earners, in Hare's opinion, but it doesn't go far enough. Labor's objective is to have all workers and their families protected in plans which provide comprehensive hospitalization, medical, dental and nursing care.

Answering questions from the floor, Hare stated emphatically that he favored the secret ballot among employes as a means of selecting the collective bargaining agent, that unions should discipline members who go on strike in violation of contracts and against the public interest and that unions had an obligation to help hospitals obtain higher payments from the government agencies that provide indigent care, so that better wages for workers would be possible.

The institute, which was sponsored jointly by the A.H.A. and the University of Chicago, attracted 120 members, who took part in a solid week of discussions covering, in addition to labor relations, such subjects as recruitment, interviewing, job analysis, personnel forms, employe training, supervisory training and salary theory. The faculty of 47 lecturers and discussion leaders included hospital and industrial personnel leaders from all over the country.

C.P.A. Approves Building for Betatron Equipment

WASHINGTON, D. C. — The Civilian Production Administration has approved construction of a $230,000 building for the Bureau of Standards here to be used to house Betatron x-ray equipment which is used in the radiation treatment of cancer, C.P.A. announced August 3.

In sixteen weeks of operation under VHP-1, C.P.A. has approved some 39,000 applications for nonresidential construction, including maintenance and repair, valued at about 1.5 billion dollars (excluding the value of the land and processing equipment), according to a report of July 29.

The trend of approvals for all field approval cases under the cutback order of May 29 has been analyzed by essentiality categories since the middle of June. Projects vitally necessary to public health and safety were responsible for 24 per cent of the total dollar value approved.

Bills Propose New Medical Legislation

WASHINGTON, D. C. — Introduced in the House and Senate July 24 were bills proposing to establish a medical service corps in the medical department of the army.

Also introduced in both Houses July 26 were identical bills called the "Women's Medical Personnel Integration Act of 1946." This proposed measure would establish in the medical department of the regular army and in the officers' reserve corps the army nurse corps, the dietitian corps, the physical therapist corps and the occupational therapist corps.

A bill introduced July 31 would establish a National Geriatrics Institute. This institute would provide for study and research in the field of geriatrics to promote the longevity of American citizens and to make available to them all the information obtainable on methods of prolonging and enjoying life.

Three Hospitals to Participate in D.C. Medical Center

By EVA ADAMS CROSS

WASHINGTON, D. C. — Signed by the President August 9, the hospital center bill, now law, carries an authorization of $35,000,000 for construction of additional hospital facilities here. The bill formerly carried two sections. Section I provided for the construction of a medical center to cost between $15,000,000 and $20,000,000. Section II provided for grants to hospitals other than those participating in the medical center.

As the bill now stands, it still carries an authorization for $35,000,000 but Section II providing help for nine other private nonprofit hospitals has been deleted. The three hospitals now committed to participate in the center are Emergency, Garfield and Episcopal.

The law auhorizes F.W.A. to enter into lease arrangements with the participating hospitals and makes the District of Columbia responsible for the repayment of the sponsor's 30 per cent of the cost, at such times and in such amounts, without interest, as Congress hereafter may direct. The participating hospitals are required to assign their physical assets to the Federal Works Agency and 30 per cent of any future sale price shall be credited toward the District's 30 per cent share of the total cost.

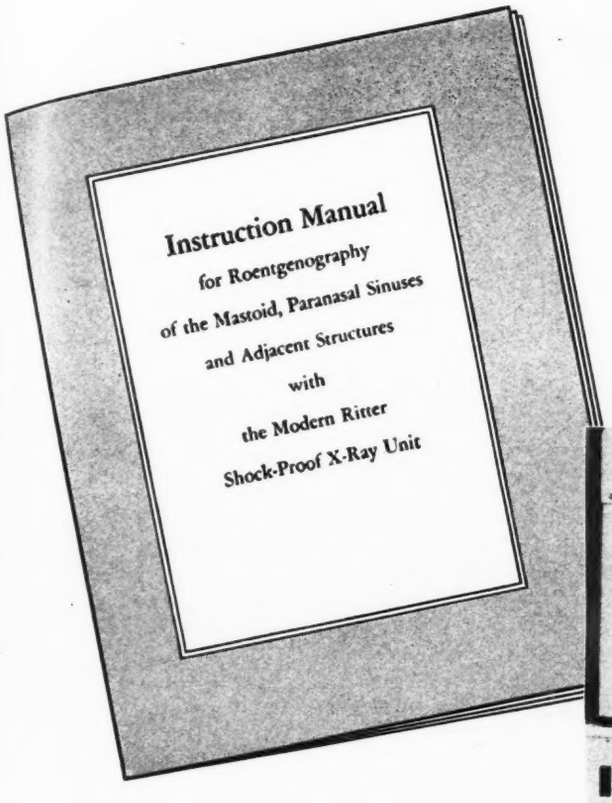
The construction of the hospital center will not meet the District's hospital needs, according to informed officials here. Competent authorities claim that 750 new beds are needed, aside from those which will be furnished by the two university hospitals now being constructed. There should be complete replacement of 2000 existing beds and remodeling of certain existing hospitals.

To Survey Naval Hospitals

WASHINGTON, D. C. — The Senate appropriations committee earmarked $50,000 on July 15 to be used to make a general administrative and operational survey of naval hospitals. The study will cover procedures, discharge of patients, records and reports system, operation of laundries, commissaries and the like.

Deadline for Transfer

WASHINGTON, D. C. — All members of the nurse corps, U. S. Naval Reserve, who wish to transfer to the regular corps must submit their applications for transfer on or before October 1. These provisions apply to nurses on terminal leave as well as those on inactive duty who may be eligible for such transfer.



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Report "Confusion" Regarding Benefits for Physician Veterans

By EVA ADAMS CROSS

WASHINGTON, D. C. — An investigation will be made by the District Medical Society here to determine whether more than 100 medical residents, veterans of World War II, in Washington hospitals are being deprived of any benefits due them under the G.I. bill, Theodore Wiprud declared in an interview August 14. Physician veterans of the District of Columbia are also looking into the matter.

A state of confusion described as "appalling" has been reported as existing here and, possibly, throughout the country over veterans' benefits to which resident physicians and interns in training in hospitals are entitled. According to an official in the Veterans Administration, V.A. will furnish books, equipment and supplies to G.I. resident physicians and interns in training in hospitals to the extent that the hospital requires all residents and interns in training, whether veteran or not, to have such items.

Fail to Act on Applications

However, administrators of several Washington hospitals have reported that they are puzzled by V.A.'s failure to act on applications for educational assistance as provided for in Public Laws 346 and 16. Although certified lists of required equipment and supplies have been forwarded to the Veterans Administration by some of the hospitals, to date no assistance has been forthcoming.

Moreover, it seems that some hospitals here have been paid tuition by V.A. for veteran resident physicians in training. Others have not. In the latter case, the residents have received subsistence allowances only. Some hospitals pay residents no salary, providing bed and board solely. Others pay from $25 to $100 a month, in a few instances above $100.

The reporter, a veteran of World War II himself, who has uncovered these facts, feels that hospitals themselves have been negligent and slipshod in the matter of keeping themselves informed as to benefits under Public Laws 346 and 16 due their veteran residents and interns in training. He ascribes the confusion to apathy in the hospital field, as well as to the Veterans Administration.

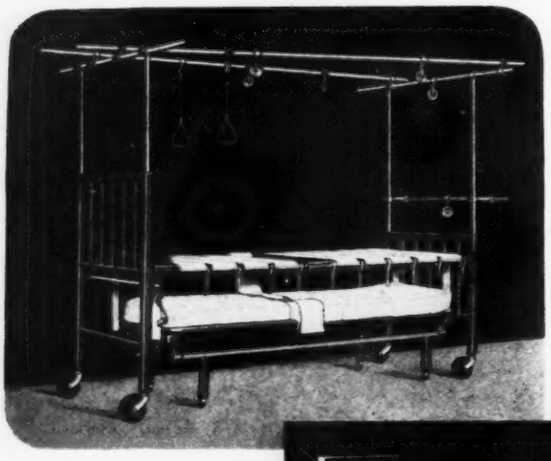
Dr. Francis J. Eisenman, superintendent of Garfield Hospital, agreed that much of the confusion which is working a severe hardship on many of the veteran trainees is due to the fact that hospitals in Washington, at any rate, have not got together and set up stand-

ards for their requirements of trainees regarding equipment, books and supplies. Training programs for these veterans are so few and so lacking in precedent that perplexing situations are bound to arise in both V.A. and hospital procedures, he said.

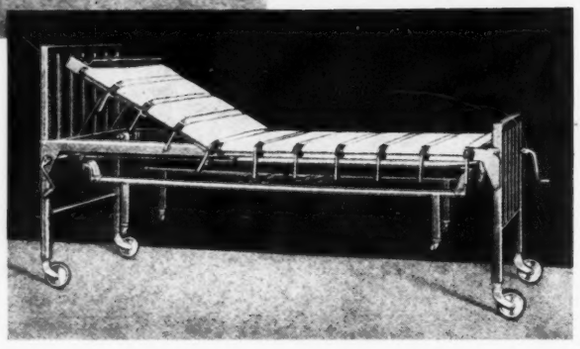
V.A. officials here declare that it is the policy of the Veterans Administration to provide veterans with such equipment and supplies which hospitals require of all residents. But it is also clear that V.A. is leaning over backward in order not to go beyond the interpretation of the law in such provisions. As one official said, "We want these veteran residents in training to have what is coming to them, but V.A. does not intend to furnish offices for physician veterans."

Streptomycin Available

Distribution of streptomycin by the C.P.A. through 1600 civilian hospitals began September 1. Physicians may obtain needed supplies of the drug by application to the nearest distributing hospital under a plan whose details the C.P.A. said would be explained before distribution began.



Spring cot with mattress lowered and cross-strap dropped for use of bedpan.



The Zimmer Fracture Bed is often used without overhead frame, as shown here.

V.A. Gets Control of G.I. On-the-Job Training Program

By EVA ADAMS CROSS

WASHINGTON, D. C. — On August 8 President Truman signed the bill giving the Veterans Administration tighter control over on-the-job training programs sanctioned by the Servicemen's Readjustment Act. The Veterans Administration claims that authority is needed to curb growing abuses of this section of the law.

The new law permits the Veterans Administration to reimburse states and local agencies for "reasonable expenses" they incur in connection with investigating, approving and supervising industrial establishments furnishing on-the-job training to veterans under the G.I. bill. It defines standards by which state agencies are to judge and approve on-the-job training establishments.

The measure prohibits payment of subsistence allowances to veterans with dependents if they are earning more than $200 per month ($175 if they have no dependents) while studying or training under the G.I. bill. The provision applies regardless of whether the veterans' wages come from on-the-job training or from outside work while they are enrolled in school.

Increase Funds for Public Assistance Under Social Security

WASHINGTON, D. C. — President Truman signed the 1946 congressional amendments to the Social Security Act August 10. It is in the nature of a stop-gap law which goes into effect October 1 and extends through Oct. 31, 1947. It is hoped by that time that Congress will have worked out basic needed changes in the social security system.

The pay roll tax of 1 per cent on employer and employe was frozen for another year. Amendments to the present act increase by an estimated $152,000,000 the annual amount of federal funds that can be granted to the states for the three public assistance programs: old-age assistance, aid to the blind and aid to dependent children.

Funds authorized for grants to states for children's services under Title V of the Social Security Act have been increased from $11,200,000 to $22,000,000. Annual grants for maternal and child health services are increased from $4,820,000 to $11,000,000; for services to crippled children, from $3,870,000 to $7,500,000, and for child welfare services, from $1,510,000 to $3,500,000.

Half of the $11,000,000 granted for state maternal and child health services must be matched by the states.

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Stress Nonprofit Aspect of Blue Cross Care, Rorem Urges Group

Many people still don't believe that Blue Cross plans are genuinely nonprofit, C. Rufus Rorem, Blue Cross commission director, reminded a public relations conference in Chicago August 16. Thus, while it is an old story to Blue Cross people, public relations efforts must constantly stress the fact that nonprofit operation results in greater public benefit, Rorem said.

The growing interest of labor unions in health coverage for their members offers an opportunity for effective Blue Cross public relations work, Rorem stated. "If unions are assured that the interests of their members can be as well protected by voluntary community plans as by a national health program, they will turn from insistence on national coverage to cooperation with local groups providing care for their own membership," he declared.

Complete protection against catastrophic illness, including insurance against medical costs, must be provided if labor is to have this assurance.

Blue Cross plans facing high utilization and dwindling reserves can either raise subscription charges or cut benefits, Rorem said, but before either of these drastic steps is taken plans can improve their financial experience by making certain they are getting high percentage enrollments and by educating doctors to control hospital admissions. These are both public relations functions, he stated.

The conference brought together plan executives and public relations directors for two days of meetings and discussions of public relations problems. Among other speakers, the conference heard Raymond E. Peterson, assistant vice president, United Air Lines; Joseph Hicks, Chicago public relations man; Bernard Barber of the department of social relations at Harvard University, and Arnold F. Emch, former assistant secretary of the American Hospital Association who is now a member of the staff of Booz, Allen and Hamilton, management consultants. R. F. Cahalane of Boston was honorary chairman of the conference and Richard M. Jones, public relations director of the Blue Cross commission, was chairman.

U. S. P. H. S. Discontinues Surplus Property Office

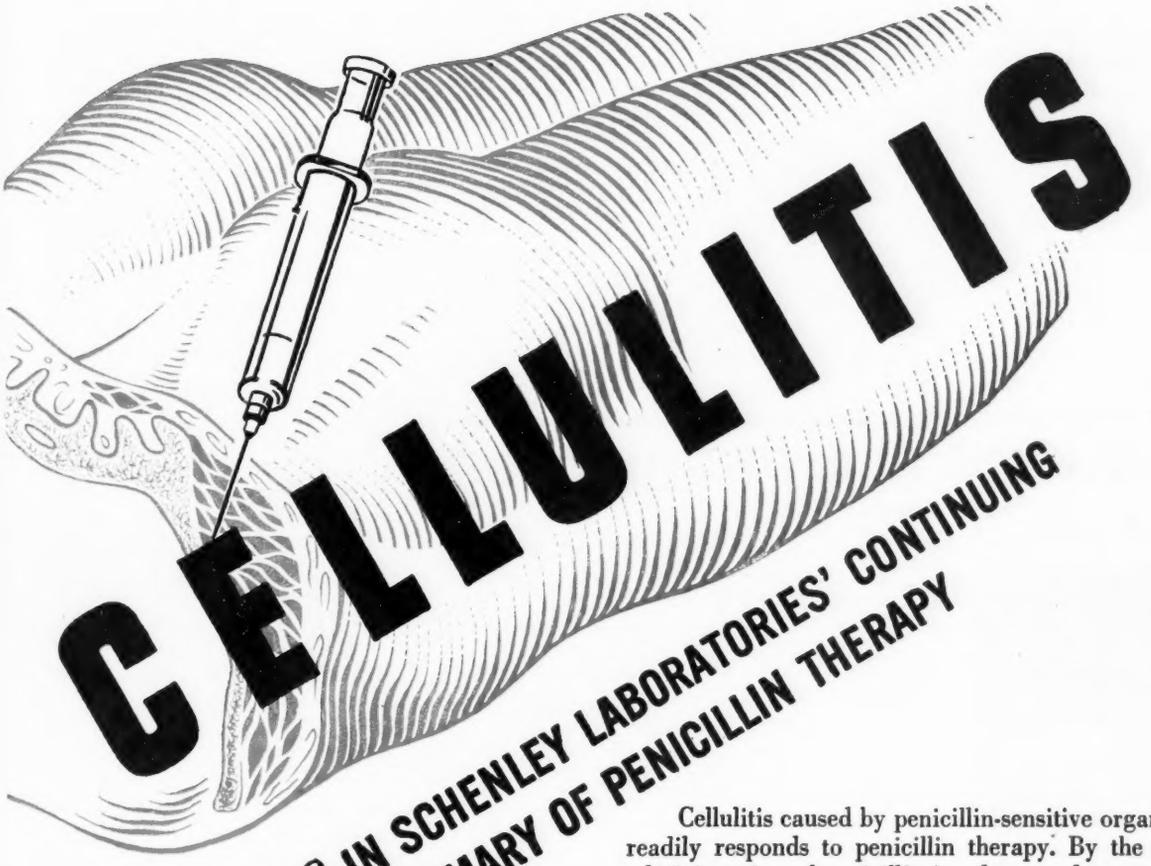
WASHINGTON, D. C.—The Division of Surplus Property Utilization, U. S. Public Health Service, was scheduled to be discontinued as of August 30, Dr. Joseph Dean, who has headed this office, said August 16. Its activities will be taken over by the Office of War Property Distribution, F.S.A., if the Federal Security Agency stays in the surplus property disposition picture.

The Division of Surplus Property Utilization has, in its brief existence, reviewed applications for real property involving the transfer of sufficient land, buildings and equipment to provide approximately 23,000 hospital beds, Dr. Dean said.

Beds provided went predominantly to mental hospitals though approximately 6000 went to tuberculosis hospitals and nearly 3000 to general hospitals. Through certifications by this office, orders for personal property valued at something like $2,500,000 have been filled for hospitals.

Will Improve Harlem Hospital

New York's overcrowded Harlem may get improved hospital facilities through an extensive construction and alteration program at Harlem Hospital. Plans, now before the city's department of housing and building, include a new eight story unit, complete modernization of the main building, a new health clinic and changes in the women's pavilion and the outpatient clinic. The estimated cost is $7,005,000.



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A daily total of 160,000 to 480,000 units, depending upon the severity of the infection, in divided doses every 2 to 3 hours by the intra-muscular route will usually be adequate to effect a cure. Duration of the course will depend upon response to therapy. If thought desirable, as a supplement to parenteral administration, penicillin may be employed by local injection or instillation of solutions containing 5,000 to 50,000 units per cc.

WOLLGAST, C. F.: *The Clinical Use of Penicillin: A Report of 115 Cases Treated in an Army Hospital, Texas State J. M. 40:225 (Aug.) 1944.* **FARQUHARSON, R. F.; GREEY, P., & TOWNSEND, S. R.:** *Results of Penicillin Therapy: A Report for the Joint Services Penicillin Committee, Canad. M. A. J. 53:1 (July) 1945.*

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Justice Department Hits Practice of Accepting Rebates

Charging that optical wholesalers and ophthalmologists were violating the Sherman Antitrust Act by fixing prices through rebates on eyeglasses, the U. S. Department of Justice last month filed complaints against certain physicians and manufacturers who, according to Attorney General Tom Clark, are simply representative of the "industrywide rebating practice."

Some physicians, the department asserted, receive as much as $40,000 a year in rebates. Actual individual cases cited in the complaint include one patient who paid $14 for lenses, $2.50 of which went to the manufacturer and $11.50 back to the doctor; another in which a $25 charge brought the physician $14.20, and a third which gave the doctor $12.90 out of $22.

"All such practices are clearly in violation of the principles of medical ethics," said an editorial in the *Journal of the American Medical Association* following publication of the complaints. The *Journal* quoted a resolution approved by the association's house of delegates in 1942 to the effect that rebating was not only unethical but also "disreputable and unscrupulous" and might "besmirch the reputation of the entire medical profession."

Several of the physicians against whom complaints were filed readily admitted the acceptance of rebates and agreed with the Attorney General that the practice was industrywide. "What's wrong with it?" one doctor was quoted in the newspaper as asking.

Form Association of Practical Nurses

WASHINGTON, D. C.—A newly formed association for practical nurses announced a campaign August 9 to seek more training opportunities and an official licensing system for members of the vocation. The Association of Undergraduate and Practical Nurses of the District of Columbia has arranged for refresher courses at the Burdick Vocational School beginning in September.

Moreover, Dr. James A. Gannon, physician member of the board of education, has proposed immediate training courses in local hospitals. He has also asked the D. C. Medical Society to support other association objectives. The association plans to appeal to the commissioners again to require licensing and registration of the 1000 or so practical nurses in Washington. The Graduate Nurses' Association more than a year ago offered such a bill.

The association is also developing a plan for its own placement agency, a nonprofit organization.

Improves Nurses' Status

The U. S. Civil Service Commission has at length reclassified all "subprofessional" nursing positions into the "professional and scientific service," the American Nurses' Association announces. All positions requiring full status as a graduate nurse are covered by the reclassification. The new status will bring more adequate salaries and greater professional satisfaction to hundreds of nurses subject to federal civil service appointment, it is said.

Opens Cancer Clinic

The Hospital for Joint Diseases, New York City, has opened a cancer prevention clinic organized along lines suggested by the New York City cancer committee. Dr. J. J. Golub, director of the hospital, and Dr. Harold D. Davidson, in charge of the clinic, studied similar clinics for several months before inaugurating the new service. They also trained necessary personnel for the specialized work.

The new antibacterial... FURACIN

Furacin Soluble Dressing is being used successfully in the treatment of: infected surface wounds, or for the prevention of such infection; infections of third and fourth degree burns; carbuncles and abscesses after surgical intervention; infected varicose ulcers; infected superficial ulcers of diabetics; secondary infections of eczema; impetigo of infants and adults; treatment of skin-graft sites; osteomyelitis associated with compound fractures; secondary infections of dermatophytoses.

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FURACIN SOLUBLE DRESSING

Furacin—newest of the modern antibacterials—is a nitrofuran. It is effective against many gram-negative and gram-positive organisms, both in vivo[1,2] and in vitro[3,4]; its antibacterial spectrum[3] compares favorably with those of other modern antibacterial agents. It is low in toxicity[5]; is effective in the presence of wound exudates; possesses excellent stability. Sensitization occurs infrequently.

Furacin Soluble Dressing contains 0.2% of this new antibacterial (5-nitro 2-furaldehyde semicarbazone), in an anhydrous base composed of carbowax (75%) and propylene glycol (25%). It melts at body temperature; its low surface tension facilitates spreading to all parts of wounds. Being water soluble, it mixes with wound exudates, penetrating pockets of pus and blood. It does not macerate the skin; is not irritating to tissue; does not retard the healing rate of wounds.

Full details will be sent you on request to The Medical Director, Eaton Laboratories, Inc., Norwich, New York.

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1. Neter, E., & Lambarti, T. G., Am. J. Surgery. In-press
2. Snyder, M. L., Kiehn, C. L., & Christopherson, J. W., Military Surgeon *97*:380, 1945
3. Dodd, M. C., & Stillman, W. B., J. Pharmacol. & Exper. Therap. *82*:11, 1944
4. Cramer, D. L., & Dodd, M. C., J. Bacteriology *51*:293, 1946
5. Krantz, J. C., & Evans, W. E., J. Pharmacol. & Exper. Therap. *85*:324, 1945

Reveal Amounts to Be Allocated to States for Hospitals

On August 21 Surgeon General Parran released the allotment figures to the states for the five year hospital construction program authorized in the Hospital Survey and Construction Act.

The preliminary estimates of the amounts to be allotted are as follows.

State	Allotments: Survey and Planning $3,000,000	Allotments: Construction $75,000,000
Ala.	$ 62,422	$ 2,888,925
Alaska	10,000	40,200
Ariz.	13,482	452,175
Ark.	39,294	1,968,300
Calif.	185,820	1,957,875
Colo.	24,279	657,300
Conn.	40,474	421,950
Dela.	10,000	86,625
D. C.	19,145	298,350
Fla.	47,141	1,461,900
Ga.	68,735	2,978,775
Hawaii	10,119	237,525
Ida.	10,531	293,550
Ill.	172,752	2,771,175
Ind.	77,526	1,727,775
Iowa	51,182	1,341,675
Kan.	37,908	933,750
Ky.	57,672	2,589,600
La.	53,631	2,156,850
Maine	17,671	454,875
Md.	46,167	870,675
Mass.	93,515	1,595,550
Mich.	124,372	2,172,000
Minn.	56,876	1,655,700
Miss.	45,548	2,403,825
Mo.	79,679	2,282,550
Mont.	10,355	231,825
Neb.	26,461	685,200
Nev.	10,000	49,575
N. H.	10,207	342,375
N. J.	93,928	1,313,775
N. M.	11,210	457,500
N. Y.	282,492	2,945,100
N. C.	76,287	3,432,825
N. D.	11,889	308,475
Ohio	156,144	2,692,575
Okla.	44,427	1,640,550
Ore.	27,317	460,875
Pa.	209,243	4,551,675
Puerto Rico	46,049	2,430,525
R. I.	15,989	280,275
S. C.	41,123	1,976,775
S. D.	12,066	359,625
Tenn.	64,812	2,673,300
Tex.	145,051	4,842,075
Utah	13,541	365,100
Vt.	10,000	214,725
Va.	64,310	2,210,175
Wash.	44,722	512,100
W. Va.	39,294	1,555,650
Wis.	67,142	1,622,925
Wyo.	10,000	144,975
TOTAL	$3,000,000	$75,000,000

WHEN YOU WANT TOP QUALITY IN HOSPITAL EQUIPMENT

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Especially is this true when U·S·S Stainless Steel is used. This *perfected*, time-tested Stainless is so uniform in composition, in finish, and fabricating qualities that it allows the manufacturer the widest latitude in design, permits him to employ the most advanced fabricating techniques . . . to give you equipment that will deliver the utmost in service.

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Nurse Enrollments in New York City Reach Record Low

New York City's nursing schools are showing the lowest number of enrollments in their histories, Virginia M. Dunbar, dean of the Cornell University-New York Hospital School of Nursing, reported August 23. Fall term enrollments in the city's 16 schools are from 25 to 100 per cent short of capacity, Miss Dunbar declared, quoting statistics gathered by the Greater New York Hospital Association as of August 5. Reports reveal that some 4488 additional nurses are needed in 85 New York hospitals.

In considering the need for nurses, however, Miss Dunbar warned, there is danger that not sufficient emphasis will be placed on the quality as well as on the quantity of nurses now being trained.

Nurses now must learn more than mere technicalities in bedside nursing, she continued; they must be equipped to understand social and economic factors affecting national health and welfare. They must have a thorough knowledge of all community organizations in order to enlist the cooperation of groups engaged in related activities, such as social welfare agencies.

Broadening the university training program would encourage girls to go into nursing by establishing it more firmly as a profession, Miss Dunbar stated. Only 4 per cent of the students admitted to nurses' schools last year had received as much as two years of college training.

New York City to Participate in Health Insurance Plan

A report recommending participation in the Health Insurance Plan of Greater New York was submitted to the New York City Board of Estimates by a special committee appointed by Mayor O'Dwyer. The report, which estimated the city's share of the cost of thus insuring its employes at $5,000,000, declared that the $500,000 appropriation for that purpose in the 1946-47 budget should be adequate to take care of the first enrollments of city workers.

In its report the committee declared that it had considered, at the request of the United Medical Service, Inc., and Group Health, Inc., the availability of those services to city workers but had rejected them after carefully studying the data that was submitted by their representatives.

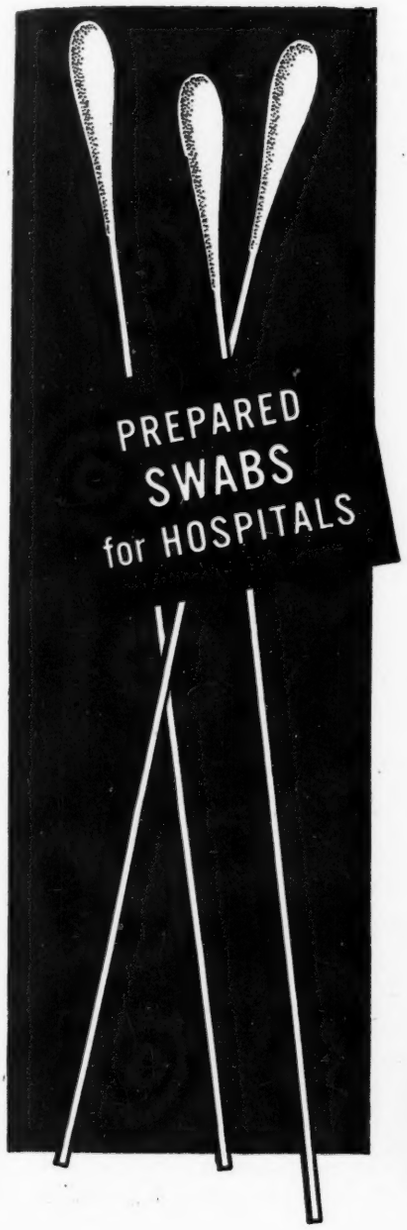
The report said the outstanding question in the minds of the committee members in considering the various plans was: "Will any one of these plans mean the end of the personal doctor-patient relationship?" All three plans, the committee concluded, would preserve that relationship, but the Health Insurance Plan would provide more advantages and fewer limitations than the two others.

The report noted that the $5000 ceiling set in the Health Insurance Plan on annual incomes of subscribers would provide far wider coverage for city employes than would the lower ceilings of the two other proposals.

The report estimated that 87,500 city employes, or half of those on the city pay roll, would enroll in the next few years, making the city's contribution $38,499 for each 1000 employes, or an annual total of $3,368,662. The report suggested that the total estimated cost be fixed for safety's sake at $5,000,000. The calculated cost was on the basis of a city contribution equal to that made by each enrolled employe.

Enrollment of city employes in the plan, according to the report, would result in benefits far outweighing the cost to the city or its employes.

Action on the report was deferred by the board to permit Controller Lazarus Joseph to study administrative costs connected with municipal participation.



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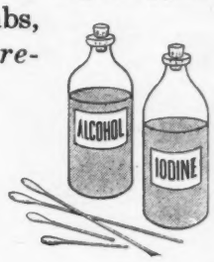
In the thousands of hospitals in which the use of ready-prepared swabs is standard practice, valuable hours of nurses' time, formerly occupied in preparing handmade swabs, are now saved for more important duties.

When in need of regular hospital size 6″ single-tipped applicator swabs, buy *ready-prepared swabs.*



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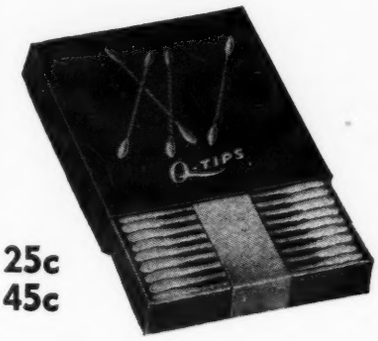

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Nurse Anesthetists Announce Program of Annual Session

The four day annual meeting of the American Association of Nurse Anesthetists will be held in Philadelphia September 30 to October 3 concurrently with the A.H.A. convention.

Preceding the convention will be a two day assembly for directors of schools of anesthesiology for nurse anesthetists. At this time the new curriculum devised by the association's curriculum committee will be presented. Statistical results of the last two qualifying examinations will be given to the directors of the schools.

A panel on interdepartmental relationships will be one feature of the convention, with a surgeon, an administrator, a medical director and a nurse anesthetist, Ruth Bergman, as participants. Dr. Malcolm T. MacEachern will be the coordinator.

Another big session will be a symposium on "How Can the Anesthetist Best Serve the Obstetrical Patient and the Newborn?"

The banquet speaker is to be Besse Howard of the Columbia Broadcasting System in Philadelphia.

D. C. to Establish Cancer Bureau

WASHINGTON, D. C. — The District of Columbia Health Department plans to open a cancer bureau, according to George C. Ruhland, the district health officer, August 9. An expanded cancer program has been made possible through a grant from the U. S. Public Health Service of $11,800. Research work will continue to be left to the Public Health Service with its more adequate facilities, but the bureau, headed by a cancer specialist, will work on problems of early diagnosis and treatment of the disease in Washington.

Of great assistance to the new bureau will be the national cancer research project just established at Gallinger Hospital. A U. S. Public Health specialist and a technical staff will study problems of the disease as revealed by the many cancer patients at Gallinger.

Dr. Ruhland has asked the local medical societies to support voluntary reporting of all cancer cases in the city. If such cooperation is not forthcoming, however, Dr. Ruhland says that he will ask the commissioners for a new regulation compelling the reports.

Hospital Picketed by Remote Control

Picketing at a distance was the unusual maneuver used by the Building Service Employes Union of Seattle in an effort to gain recognition as collective bargaining agent for employes at the Virginia Mason Hospital. Placard-carrying pickets toured the downtown business district of Seattle but did not appear in the neighborhood of the hospital.

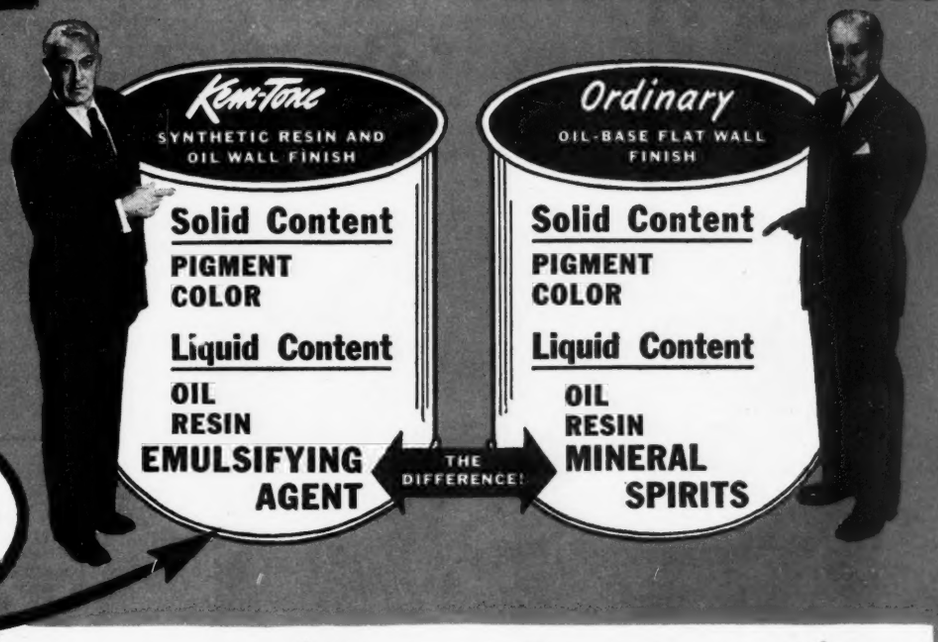
"We're not stopping the hospital from functioning," Ward Coley, business agent for the union, told newspapermen, "but we are trying to acquaint the public with the situation. We may move closer to the hospital later."

The union claimed 76 of 80 eligible employes were union members but that the hospital nevertheless refused to bargain with the union. The hospital, on the other hand, asserted that union negotiations were being carried on at the time the picketing began.

Buyers Group Holds Meeting

The National Institute of Governmental Purchasing held its first annual conference and products exhibit in Chicago, August 19 to 21. The institute is a nonprofit, technical and educational organization of governmental buying agencies of the United States and Canada, its purpose being to raise the standards of public buying. Federal procurement officers and other authorities were on the program.

Check THE ADVANTAGES OF Kem-Tone OVER ORDINARY FLAT WALL PAINTS FOR MAINTENANCE PAINTING JOBS!



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Kem-Tone gives you everything .. Pigments .. Color Oil...Resin...*ALL THE DURABILITY AND QUALITY* of finest flat wall finishes *PLUS* Special Advantages!

Look at the two cans above. One is a can of Kem-Tone. The other—oil-base flat wall paint. Note that each can contains pigment, color, oil and resin.

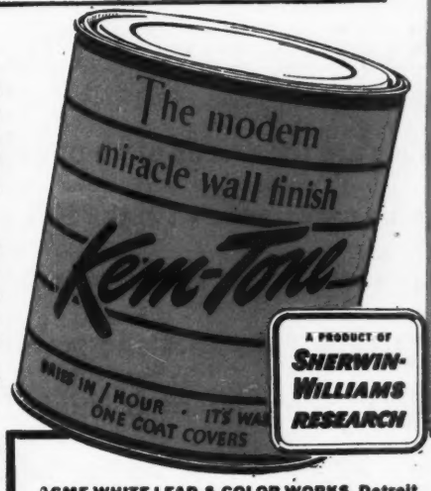
The only difference in the contents of these two cans is the emulsifying agent used in Kem-Tone and the mineral spirits in the oil-base paint. As you well know, the purpose of these mineral spirits is to thin the paint, make it brushable. As the paint dries, the mineral spirits evaporate.

The emulsifying agent used in Kem-Tone serves a different purpose. It makes possible the mixing of Kem-Tone's oil and resin with water. This water, added "on the job," makes Kem-Tone brushable. Furthermore, it gives you up to 1½ gallons of paint ready-to-apply, for every gallon of Kem-Tone paste.

Obviously, neither mineral spirits nor water have anything to do with the beauty or durability of either oil-base paint or Kem-Tone. The way both paints look and how they wear depend upon their PIGMENT, COLOR, OIL and RESIN.

That is why we say "There's no finer flat wall finish than Kem-Tone." Kem-Tone materials are absolute tops in quality. They are scientifically blended with highest skill. Kem-Tone brings you everything offered by the highest quality oil-base flat wall paint!

More than that, Kem-Tone gives you extra speed and ease of application, quicker-drying, freedom from odor of paint thinners. And—unlike the average oil-base flat wall paint, which dries with a sheen—Kem-Tone dries to a perfectly flat matte finish. That's a feature decorators for years have wanted in a durable, washable wall finish!



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New York Hospitals Close 1200 Beds; Lack Nursing Help

Nearly 6000 vacancies on the nursing staffs of hospitals and health agencies in New York City have made it necessary to close 1200 beds at a time of unprecedented demand for hospital facilities, a survey made by the *New York Times* revealed recently. No solution is in sight, the *Times* said; in fact, nursing and hospital officials are predicting that the situation will get worse with the increasing incidence of illness in fall and winter.

Factors contributing to the shortage of nurses are, according to the survey: poor pay for hospital nurses compared to nurses in industry, doctors' offices and nonnursing jobs; shorter hours in nonhospital jobs; retirement and marriage of nurses; opportunities for advanced study under the G.I. bill, and the housing shortage.

Volunteer help in New York hospitals has also declined since the war ended, the report said, contributing to the difficulty. However, hospitals maintained that service to the critically ill has not deteriorated, since nurses remaining in hospitals are carrying on without needed assistance.

Seek Fitness Standards for Automobile Drivers

WASHINGTON, D. C. — The District Medical Society formed a committee of prominent physicians here August 9 to study the question of physical handicaps and their relation to automobile driving.

The action was taken at the suggestion of the District director of vehicles and traffic following a week of unprecedented motor accident tolls in the nation's capital. The traffic director said that he hoped to obtain valuable advice from the physicians in connection with drivers' tests and issuance of operators' permits.

Outstanding among proposals under consideration in the department of vehicles and traffic is that a doctor's certificate of physical fitness to drive be required of each applicant for an original permit or a renewal.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Palliser Hotel, Calgary, Nov. 6-8.
AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Philadelphia, Sept. 30-Oct. 4.
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Bellevue-Stratford Hotel, Philadelphia, Sept. 30-Oct. 3.
AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Philadelphia, Sept. 28-30.
AMERICAN COLLEGE OF SURGEONS, Clinical Congress, Public Auditorium, Cleveland, Dec. 16-20.
AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Pennsylvania, New York, Sept. 4-7.
AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY, St. Louis, Sept. 8-12.
AMERICAN DIETETIC ASSOCIATION, Netherland Plaza Hotel, Cincinnati, Oct. 14-18.
AMERICAN HOSPITAL ASSOCIATION, Hotels Bellevue-Stratford and Benjamin Franklin, Philadelphia, Sept. 30-Oct. 3.
AMERICAN NURSES' ASSOCIATION, Atlantic City, N. J., Sept. 23-27.
AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Bellevue-Stratford Hotel, Philadelphia, Sept. 27-28.
MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Hotel Statler, Washington, D. C., Oct. 31-Nov. 1.
MISSISSIPPI STATE HOSPITAL ASSOCIATION, Edgewater Gulf Hotel, Edgewater Park, Oct. 17-19.
MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 29-30.
NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 12-13.
NATIONAL COMMITTEE FOR MENTAL HYGIENE, Hotel Pennsylvania, New York City, Oct. 30-31.
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC., Atlantic City, N. J., Sept. 23-27.
NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS, Hotel Pennsylvania, New York City, Nov. 25-27.
NEBRASKA HOSPITAL ASSEMBLY, Hotel Cornhusker, Lincoln, Oct. 21-22.
NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.
OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 8-10.
OKLAHOMA STATE HOSPITAL ASSOCIATION, Oklahoma City, Nov. 21-22.
ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 21-23.
PENNSYLVANIA HOSPITAL ASSOCIATION, Pittsburgh, April 23-25.
SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Buena Vista, Biloxi, Miss., April 10-12.
TEXAS HOSPITAL ASSOCIATION, Rice Hotel, Houston, March 27-29.

Periodic Acne!

The ovaries appear to have a definite but variable influence on the condition of the skin. The effect is upon the sebaceous glands, primarily, and a disturbance in this ovariandermal relationship seems to be responsible for the quite common "periodic acne". The skin eruption comes and goes with the menstrual cycle. Periodic headaches may be associated with the condition.

Ovarian Concentrate Armour has been found to be quite beneficial in this syndrome. This preparation is a special sterol fraction, free from demonstrable estrogenic properties, derived from the fat and lipoid fraction of whole ovaries by a special process originated in the Armour Laboratories. It is put up in sealed gelatin capsules (glanules). The recommended dose for periodic acne is one glanule t. i. d. for one month. After this, one glanule t. i. d. for seven to ten days premenstrually may suffice. They should be taken with meals.

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Ovarian Concentrate Glanules

Have confidence in the preparation you prescribe — specify **"ARMOUR"**

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HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

Record Librarians Inaugurate Five Day Training Programs

A five day in-service training program for medical record librarians will be held in 23 or more cities between September and June, arranged by the educational board of the American Association of Medical Record Librarians. A grant of $22,000 from the National Foundation for Infantile Paralysis makes this extension program for the librarians possible.

Registrants will be limited to 60 at each center. A tuition fee of $20 will be asked of each enrollee so that the program may be carried on for at least another two years. Surplus tuition fees will be used in creating a correspondence course for those librarians who have already taken the extension course, Alphild Anderson, president of the association, points out.

Centers at which the courses will be held include: Rochester, N. Y.; Portland, Maine; New York City; Baltimore; Richmond, Va.; Miami, Fla.; Atlanta, Ga.; Charlotte, N. C.; Newark, N. J.; New Orleans; Memphis, Tenn.; Kansas City, Mo.; Los Angeles; San Francisco; Portland, Ore.; Spokane, Wash.; Omaha, Neb.; Birmingham, Ala.; Nashville, Tenn.; Indianapolis; Columbus, Ohio; Pittsburgh; Minneapolis.

$100,000,000 Cancer Control Bill Defeated

WASHINGTON, D. C. — The $100,000,000 cancer control program was defeated in the House July 27. The measure sought authority for the President to mobilize at some convenient place in the United States an adequate number of the world's outstanding experts and coordinate and utilize their services in a supreme endeavor to discover means of curing and preventing cancer.

The identical bills H.R. 4502 and S. 1875 had both been reported out favorably from House and Senate committees. The Senate report said that at least 500,000 people in the United States are suffering from cancer at the present time. As many as 20,000,000 people who are living today in this country will eventually die of this disease.

The chief opponents of the bill said that cancer research can be carried out as well through the Cancer Research Institute or the U. S. Public Health Service.

Restrict Hospital Visitors

No visitors to the children's wards of hospitals in the province of Quebec are being permitted until poliomyelitis is brought under control. In Montreal 125 cases had been reported by the tenth of last month.

V. A. Seeks Site for New Hospital in Washington, D. C.

WASHINGTON, D. C. — The Veterans Administration has begun negotiations to obtain a site for the new veterans' hospital here, it was reported August 7. The tract contains a million square feet of land and is located on the Virginia side of the Potomac near the Arlington National Cemetery. The site is not far from downtown Washington and it is near the Georgetown University Hospital and the new George Washington University Hospital.

The new veterans' hospital, to cost approximately $15,000,000, will contain facilities for 750 beds. It will supplement Mount Alto Veterans Hospital on Wisconsin Avenue.

The Federal Board of Hospitalization declares that several sites are under consideration and that both Arlington and Montgomery counties have been surveyed for possible locations. Many weeks of investigation remain before a recommendation can be made to President Truman, according to an official of the board.

Rochester Starts "Farm-Out" Plan

Under what many observers believe to be a history making "farm-out" agreement, Dr. A. C. Aufderheide last month started an internship at the 120 bed Geneva, N. Y., hospital. Dr. Aufderheide, who will stay at Geneva for two months, was the first intern appointed to Geneva by the Rochester General Hospital under the sponsorship of the Council of Rochester Regional Hospitals, which was organized with the help of the Commonwealth Fund to improve medical and hospital service throughout the area by coordinating existing facilities and services.

Dr. Aufderheide and several other Rochester General interns volunteered to accept assignments to Geneva, and a schedule of two month appointments through June 1947 has been worked out.

Campaign Fund Oversubscribed

To finance a 100 bed addition, Bronson Methodist Hospital recently undertook a drive for $800,000, the largest such drive ever attempted in Kalamazoo, Mich., where the hospital is located. Within three weeks after the countywide campaign for funds was started subscriptions reached $1,132,381. Included was a $250,000 gift from the Kalamazoo Foundation contingent upon the meeting of the original campaign goal. Ketchum, Inc., conducted the fund raising drive.

OFFICIAL ORDERS

Blankets.—Commercial standard CS136-46 for wool and wool and cotton blankets for hospitals was submitted to manufacturers, distributors and users of the commodity for written acceptance on Nov. 30, 1944. Since that date the standard has been accepted for promulgation by the U. S. Department of Commerce through the National Bureau of Standards and it is now effective for new production from August 20. A printed copy, TS-4165, of the accepted standard will be mailed to each acceptor of record as soon as they are available. Non-acceptors must make specific request to the Superintendent of Documents, Washington 25, if they wish copies.

Hospital Flat Rubber Goods.—A recommended commercial standard for hospital flat rubber goods (cloth inserted, rubber or synthetic), TS-4182, has been prepared by the U. S. Department of Commerce and was sent out to producers, distributors and users of the items on July 30. The covering letter asks for a written acceptance so that it may be established as a commercial standard and be publicized by the Department of Commerce.

Price Increases.—A number of hardware items and various types of hinges were put under new ceiling prices July 26, according to an announcement made by the O.P.A. The increase represents an average advance of 32 per cent over the Oct. 1, 1941, level. Also effective on the same date was a 15 per cent increase on electric temperature controls for automatic water heaters.

The O.P.A. also announced new ceiling prices for electric motor generator sets, engine driven generator sets and turbine driven generator sets, ranging from 16 to 27 per cent over base date prices. These new prices went into effect on July 27.

Army to Build 1000 Bed Hospital in Puerto Rico

SAN JUAN, P. R. — The U. S. army will construct a 1000 bed general hospital in Puerto Rico, to provide joint medical facilities for the military personnel and the Veterans Administration patients. It is estimated that this hospital will cost approximately $22,000,000. Maj. Gen. Norman T. Kirk, surgeon general of the army, recently requested the House Appropriations Committee in Washington to appropriate $530,000 to purchase a site that has been tentatively selected for the hospital.

The general hospital will consist of three buildings: one principal structure, a mental disease hospital and a tuberculosis hospital.

Living quarters for nurses, married and single officers and non-coms will be constructed according to preliminary plans. The buildings will occupy a farm of about 200 acres of land.

The construction of this hospital will start in 1948 or earlier if appropriations are finally voted by Congress.

Rhode Island Campaigns for Student Nurses

Rhode Island's five schools of nursing will have a full quota of students for the fall classes, following a two weeks' campaign consisting of open house ceremonies, information booths in five cities and other publicity devices.

"One of the encouraging factors has been the number of requests for information from girls still in high school," Kenneth D. MacColl, chairman of the campaign, declared.

"These young ladies want to be sure they are taking the right courses in school. This is an indication of a backlog of potential nurses who will go into nursing schools when they have completed their preparatory education."

Hamilton Starts Los Angeles Survey

A countywide survey of the hospital needs of Los Angeles County, California, is being made by James A. Hamilton and Associates. The county covers 4000 square miles and has been experiencing the greatest increase in population of any county in the nation; it expects to reach 12,000,000 by 1970.

Under the direction of Mr. Hamilton, the survey staff consists of Russell C. Nye, Dorothy A. Hehmann and Charles S. Aston Jr., with Graham Davis of the Kellogg Foundation as general adviser. It will take nine months and is being financed by voluntary contributions from several sources.

Report Shortage of Resident Interns, Ambulance Drivers

WASHINGTON, D. C. — Deficiency in the city's emergency ambulance service was laid to a shortage of ambulance drivers and resident interns at Washington hospitals by Dr. Alvin R. Sweeney, superintendent of Gallinger Hospital, August 9. Dr. Sweeney's comments followed a number of recommendations by the commissioners for improvement of the service. There have been many complaints recently because of delays in removal of sick and injured to hospitals.

The commissioners have recommended to the budget director that the cost allowance to municipal hospitals be raised from $1.50 to $3.65 per ambulance. The District Emergency Ambulance Committee conceded that the rise in cost allowance will help but fears the shortages of personnel will remain.

Other recommendations call for a thorough investigation of the housing problems for ambulances and attendant personnel.

Receives Radioactive Isotopes

The Barnard Free Skin and Cancer Hospital, St. Louis, last month became the first hospital in the United States to obtain a supply of radioactive isotopes released by the federal government from the atomic research unit at Oak Ridge, Tenn. A ceremony marking the event took place August 2 at the government's atomic research laboratory. The invisible speck of carbon 14 was contained in a quantity of powder about the size of a crushed aspirin tablet, it was reported, encased for safety's sake in an aluminum and steel container. Dr. Edmund V. Cowdry, hospital director, accepted the material on behalf of the hospital's research staff.

A.C.H.A. Convention

Eight persons will complete the requirements for fellowship in the American College of Hospital Administrators and will advance to that status at the twelfth annual convocation at the Bellevue-Stratford Hotel, Philadelphia, on Sunday afternoon, September 29. Seventy administrators from the United States and Canada will attain full college membership. They have been hospital administrators five years or more and have qualified by oral and written examinations. The affiliation of 45 nominees will also be announced. The convocation will be followed by the president's reception and the annual banquet.

Hold 3000 Hospital Corpsmen

WASHINGTON, D. C. — Some 3000 hospital corpsmen will be retained beyond September 1, the date set for total demobilization, the Navy Department announced August 3. The fact that there are 32,000 sick and wounded still in naval hospitals is the reason given for keeping this group beyond the time set for the release of other eligibles.

When a corpsman has attained a total of 18 months' active duty, he is released from service. Officials estimate that the corpsmen will all be out of the service by March 1, 1947.

Sponsor $1,000,000 Hospital

The Sisters of St. Joseph will sponsor a new $1,000,000 hospital at Sudbury, Ont., overlooking Lake Ramsey. It will be a 100 bed structure. The Y-shaped plan is the work of Louis N. Fabbro, architect.

Start New Construction

Excavation has been completed for a new building at Mercy Hospital, Hamilton, Ohio. The addition, which will add 125 beds to the hospital's capacity and expand service facilities accordingly, will cost $500,000.

Quarantine Bill Passed; Goes to President

WASHINGTON, D. C. — With the passing July 30 of the quarantine bill by both houses of Congress, the District of Columbia Health Department has finally won the right to arrest and hold persons suspected of having or carrying communicable diseases.

The legislation empowers the District health officer to order any person believed infected with or a carrier of a communicable disease held by any health officer or by the metropolitan police. Health officials may order such persons detained in Gallinger Hospital until their period of infection is over.

The health officer is empowered to enter and inspect all premises or buildings in the District if necessary to carry out the provisions of the act. The commissioners may prescribe fines not to exceed $300 and jail sentences up to ninety days, or both, at the discretion of the criminal division of the municipal court.

Seek $6,000,000 for Hospital

A campaign for $6,000,000 for a new hospital and medical school at Bel Air, Calif., has been undertaken. The building project will be located on Sepulveda Boulevard near the University of California's Los Angeles campus.

Donald Nelson, motion picture executive who is chairman of the volunteer fund raising committee, asserts that the western section of Los Angeles, with 1,500,000 residents, has only 330 available hospital beds. The campaign started August 1.

Bill Urges Health Department

WASHINGTON, D. C.—One of the last bills dropped into the Senate hopper before the Seventy-Ninth Congress adjourned was a proposal on August 1 to create a federal department of health, education and security on a cabinet level. Senators Fulbright and Taft introduced the bill. A secretary would head the new department with three assistant secretaries to head the divisions of health, education and security. The sponsors declared the bill was a trial balloon to stimulate public discussion of such a measure before the new Congress convenes.

A. C. S. Sets Congress Date

The first annual meeting of the American College of Surgeons since November 1941 will be the 32d clinical congress set for Cleveland December 16 to 20. Original plans for a September meeting in New York City were changed because of an overlap with the United Nations assembly. Because of the long interval between meetings several hundred surgeons, received into fellowship in absentia, will participate in the initiation ceremonies. Many of them are war veterans.

Signs Health Program Act

WASHINGTON, D. C. — The Randolph Health Bill, recently passed by Congress, was signed by the President August 10. Dr. John W. Cronin of the U. S. Health Service has been appointed to administer the program. The Randolph Act authorizes the establishment of health clinics in individual departments and agencies of the federal government for emergency treatment. Annual health checkups and constant supervision along preventive lines will be part of the program as planned by the Public Health Service, the supervising agency.

"Educational Funds" Listed

The 1946 edition of "Educational Funds" issued by the three national nursing organizations is now available. This pamphlet lists the scholarships, loan funds and fellowships open to student and graduate nurses. It lists national resources only.

U. M. S. Offers Care to Groups of Five

Prepaid medical care in the home, office and hospital under the United Medical Service plan in New York City is now offered to groups with as few as five members, according to an announcement by Rowland H. George, president. Membership fees are $1.80 a month for the individual subscriber and $4.00 a month for family membership.

The United Medical Service now covers more than 247,000 members, and more than 10,000 physicians are participating. Subscribers to United Medical Service must be members of Associated Hospital Service, the Blue Cross plan in New York.

Atlantic Hospital Reorganized

Everett W. Jones, vice president of The Modern Hospital Publishing Company, gave an address recently at Atlantic, Ia., when the Atlantic Hospital there was taken over by a voluntary nonprofit association representative of the community. He reviewed the functions of voluntary hospitals in community life and urged support by all citizens of the hospital. Other speakers included Gerhard Hartman, director of hospitals at the University of Iowa, Dr. Walter Bierring, Iowa health commissioner, Dr. H. V. Hullerman of the American Hospital Association, and F. P. G. Lattner, Iowa Blue Cross director. Lilyan Zindell is administrator of the hospital.

Purchasing Experts to Meet

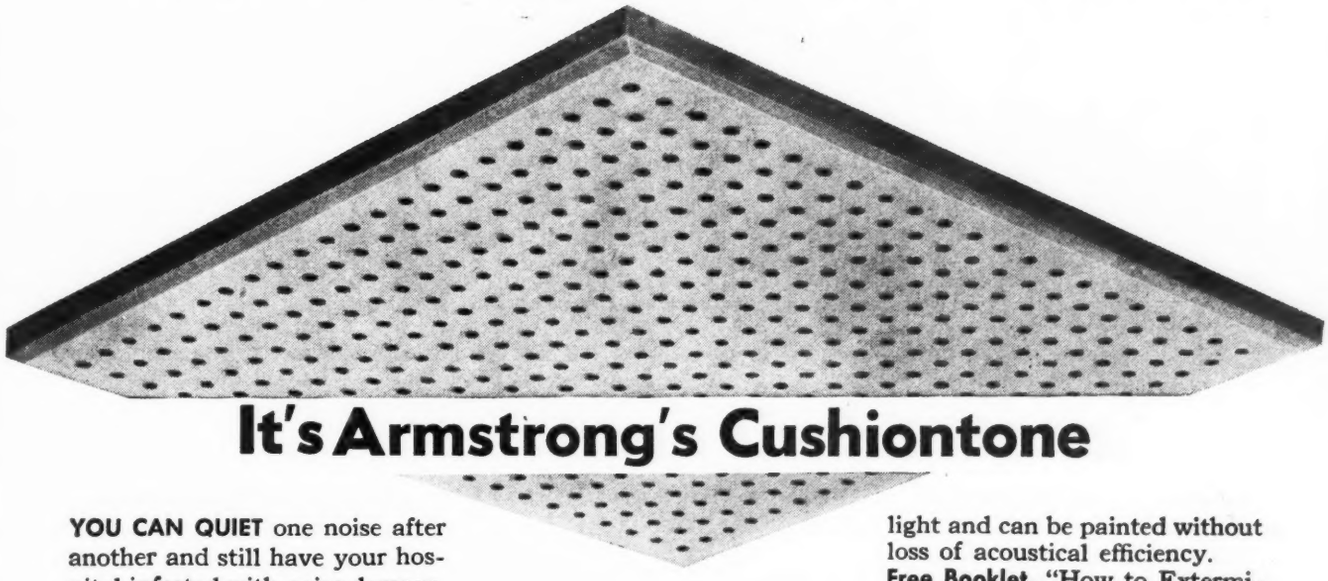
Purchasing experts from government and industry will take part in a discussion of hospital purchasing problems at the purchasing section meeting of the American Hospital Association during the convention in Philadelphia next month. Among the subjects to be discussed are: inventory and stockroom control, quality purchasing, purchasing for the small hospital and the public relations angle of hospital buying.

Study Houston Hospital Needs

The Texas Medical Center has begun an extensive survey to determine the needs for hospital care in the Houston area, with James A. Hamilton and Associates of New Haven, Conn., conducting the study. Glen Clasen, formerly of University Hospitals of Cleveland, is resident director of the survey staff. The findings will be available not only to the institutions of the center but to all hospitals and public health agencies in the area.

Silencing one noise won't endNoise Demons

But you can trap them with thisceiling



It's Armstrong's Cushiontone

YOU CAN QUIET one noise after another and still have your hospital infested with noise demons. Clattering equipment, buzzers, footsteps, loud voices—all breed noise demons. These pests worry your patients and fray the nerves of your staff.

But noise demons can be ended—once and for all—with economical ceilings of Armstrong's Cushiontone*. The 484 deep drilled holes in each 12" square of this fibrous material absorb up to 75% of all noise that strikes the ceiling. Cushiontone is an excellent reflector of light and can be painted without loss of acoustical efficiency.

Free Booklet, "How to Exterminate Hospital Noise Demons," gives all the facts. Write for your copy to Armstrong Cork Company, 5709 Stevens Street, Lancaster, Penna.

*REG. U. S. PAT. OFF.

MADE BY THE MAKERS OF ARMSTRONG'S LINOLEUM AND ASPHALT TILE

ABOUT PEOPLE

(*Continued From Page 90*)

hospitals and mental health to the Maine Department of Institutional Service. Dr. Sleeper, who resigned as assistant to the Commissioner of Mental Health in Massachusetts, reported for duty September 1. He succeeds **Dr. Forrest C. Tyson,** retired.

A. C. O'Connor, recently released from the army medical administrative corps with the rank of major, has been selected as administrator of Newark Hospital, Newark, Ohio, succeeding **John King** who is going to Reid Memorial Hospital, Richmond, Ind. Prior to his army service, Mr. O'Connor was administrator of Dodge County Hospital, Fremont, Neb.

S. K. Hunt, administrator of Grace Hospital, Morganton, N. C., for almost nine years, has submitted his resignation which will take effect on November 1. Mr. Hunt is one of the organizers of the Catawba Valley Conference of Hospital Executives, which he serves as president, and is a member of the advisory committee of the North Carolina Medical Care Commission. His successor at Grace Hospital has not been announced.

Sister Mary Bernard, formerly administrator of St. Francis Hospital, Kewanee, Ill., has been made Superior of the order. **Sister Ann,** who was formerly at St. Anthony's Hospital, Rock Island, Ill., succeeds her as head of the hospital. The hospital recently dedicated a new three story nurses' home, with a capacity for 45 students.

Dr. Kelso A. Carroll is the new head of Hines Hospital, the Veterans Administration medical center at Hines, Ill. Dr. Carroll is a veteran of World Wars I and II and has served with both the U. S. Public Health Service and the Veterans Administration.

William L. Lockhart is the new administrator and business manager of the Leake Van Beber Clinic Hospital, Gladewater, Tex. He was formerly business manager at Rollins-Brook Hospital and Clinic at Lampasas.

Owen U. Britton who served as wartime head of Washington Hospital, Washington, Pa., during the absence of **Col. William E. Barron** has been confirmed in the appointment as superintendent of the hospital.

Robert Jolly, former administrator of Memorial Hospital, Houston, Tex., has been appointed director of public relations of that hospital.

Harvie M. Clymer, wartime superintendent of Doctors Hospital, Philadelphia, has left that post upon the return of **Supt. Thomas Carden** from the medical administrative corps and will direct the medical administrative activities of the Veterans Administration in Pennsylvania, New Jersey and Delaware. **Thomas F. Kellett,** who became business manager of Friends Hospital, Philadelphia, in May, has resigned that position to assist Mr. Clymer.

Forst R. Ostrander has been selected as administrator of Iroquois Hospital at Watseka, Ill. Mr. Ostrander will devote much of his time to reorganizing the hospital and assisting the board of trustees in planning for a 50 bed addition to the hospital and for a new power plant and laundry.

Department Heads

Ethel M. Hopkins has been appointed superintendent of nurses and principal of the school of nursing of White Cross Hospital, Columbus, Ohio, to fill the vacancy created by the resignation of **Lulu E. Ferris.** Miss Hopkins is a graduate of Lakeside Hospital School of Nursing, now affiliated with Western Reserve University, and of Teachers' College, Columbia University.

Dorothy A. Hehmann, whose resignation as personnel director of Grace-New Haven Hospital, New Haven, Conn., was reported last month, has joined the staff of James A. Hamilton and Associates, hospital consultants.

Frank Bruesch, purchasing agent of Harper Hospital, Detroit, has added the duties of personnel director to his present position. He will be assisted by two full time personnel workers.

Margaret Margrave is the new personnel director of Wesley Memorial Hospital, Chicago. She was formerly assistant to the director of personnel for the Midwest area of the American Red Cross.

Madeline F. Dill, R.N., has been appointed director of nurses and principal of the school of nursing at Rhode Island Hospital, Providence, R. I. A graduate of the school she now heads, Miss Dill has recently been assistant professor of nursing at Rhode Island State College.

Dr. Harrison D. Goehring has been appointed full time director of the department of roentgenology at Mountainside Hospital, Montclair, N. J., succeeding **Dr. Albert G. Jahn,** who had been serving on a part time basis since 1938.

DeLores Joan Schemmel has joined the staff of Huntington Memorial Hospital, Pasadena, Calif., as assistant director of nursing.

Dr. Harry Goldblatt, formerly of Western Reserve University Medical School, has been named director of the Cedars of Lebanon Hospital Research Institute, Los Angeles.

G. Gwendolyn Taylor has been appointed chief dietitian of Strong Memorial Hospital, Rochester, N. Y., replacing **Grace Carden** who retired on August 1. Miss Taylor was in charge of dietetics for the Canadian army during the last two years, carrying the rank of major in the Royal Canadian army medical corps. Another change in personnel announced at Strong Memorial is the appointment of **Nina M. Hommel** as chief executive assistant in the admitting office. She succeeds **Elizabeth Goldthwait** who held the post from 1926 until her retirement August 1.

Jannette Hughes, R.N., director of Methodist Hospital School of Nursing, Dallas, Tex., resigned August 15. Miss Hughes organized the nursing school and has developed and directed it for nineteen years. Other faculty resignations announced at the same time are those of: **Betty McFarland, R.N.,** assistant director; **Mary Stilwell, R.N.,** educational director; **Marie Holley, R.N.,** supervisor of the outpatient department and instructor in public health nursing; **Mrs. Marie Faust, R.N.,** supervisor of the pediatric department and instructor in pediatric nursing, and **Bertha Maria Broch, R.N.,** obstetrical supervisor.

Dr. Charles Leonard Brown has been appointed dean of Hahnemann Medical College, Philadelphia. Dr. Brown, who is head of the department of medicine, Temple University Hospital, started his new duties September 1.

Dr. Bruce K. Wiseman has been named chief of staff of St. Francis Hospital, Columbus, Ohio, the Ohio State University board of trustees has announced. Dr. Wiseman has been chairman of the department of medicine of the university college of medicine since 1944. He succeeds **Dr. Isaac B. Harris** who becomes emeritus chief of staff and medical director.

Dr. Thomas McP. Brown, associate professor of medicine at Johns Hopkins University, has become chief of medicine at the Veterans Administration's Mount Alto Hospital, Washington, D. C. He is a specialist in heart disease, arthritis and tropical diseases.

Miscellaneous

Caroline Hauenstein of Tell City, Ind., has been appointed educational director of the Indiana State Board of Examination and Registration of Nurses, succeeding **Mary Walsh.**

R.Adm. Dallas G. Sutton, (MC) U.S.N. (Rt.), joined the Washington Service Bureau staff of the American Hospital Association in September as director of study of government hospital relations. Admiral Sutton will serve as a liaison officer between the association

and the federal government in matters concerning the federal hospital program.

Dr. Richard F. Kieffer has been appointed medical director of both the Associated Hospital Service of Baltimore and the proposed Maryland Medical Service. He will assume his new duties on September 15.

Dr. Allen O. Whipple, professor of surgery at Columbia University and director of surgical service of Presbyterian Hospital, New York City, has accepted a position on the medical faculty of the American University of Beirut. Dr. Whipple will retire September 30 after thirty-five years on the faculty at Columbia.

Col. John M. Caldwell, M.C., is the new chief of the army neuropsychiatry consultants division, succeeding **Brig. Gen. William C. Menninger** who has returned to civilian status.

Florence G. Blake, assistant professor of pediatric nursing at Yale University, and **Catherine E. Scheckler,** associate professor of public health nursing at the University of Pittsburgh, have been appointed to the faculty of nursing education at the University of Chicago. Miss Blake will teach nursing care of children and Miss Scheckler, maternity nursing. Both courses are innovations in the nursing education program and are being conducted under a three year grant from the W. K. Kellogg Foundation.

J. Lawrence Hopp has resumed the practice of architecture with offices in Mount Lebanon, Pittsburgh. Mr. Hopp has designed several hospitals, one of the most recent being the proposed St. Clair Memorial in Pittsburgh.

Jack Gage has been appointed director of Associated Hospital Service, the Blue Cross plan at Danville, Ill., succeeding **Thomas Graham,** who has moved to California. Mr. Gage comes to Blue Cross from the Standard Oil Company of Indiana, with which he was associated for twelve years, and the navy, which he served as a communications officer during the war.

Deaths

S. Hawley Armstrong, executive secretary of the Hospital Association of Pennsylvania, died of a heart attack July 22. Mr. Armstrong first joined the association ten years ago as assistant secretary, later became full time executive secretary. Mr. Armstrong, who was born at Media, Pa., 45 years ago, was employed in the welfare department of the State of Pennsylvania before he joined the hospital association staff.

Emil M. Hauge, superintendent of Fairview Hospital, Minneapolis, since 1937, died of a heart attack in July. Mr. Hauge was a fellow of the American College of Hospital Administrators, a member of the American Hospital Association and of the Minnesota Hospital Association, which he served as president in 1943 and later as trustee.

Dr. Henry Greenberg, medical superintendent of City Hospital, Welfare Island, New York City, died recently. Dr. Greenberg was formerly medical superintendent of Morrisania City Hospital, New York City.

Dr. Herbert A. Durham, for more than twenty-four years chief surgeon at the Shreveport, La., unit of the Shriners' Hospitals for Crippled Children, died early this year.

Edmund H. Sears, president of the Framingham Union Hospital, Framingham, Mass., since 1933, died July 23 of coronary heart disease. Mr. Sears headed the drive for a million dollar hospital expansion fund to build additions already planned.

THE BOOKSHELF

POISONS, THEIR CHEMICAL IDENTIFICATION, AND EMERGENCY TREATMENTS. *By Vincent J. Brookes, Sergeant, New Jersey State Police, and Hubert N. Alyea, Associate Professor of Chemistry, Princeton University. New York: D. Van Nostrand Company, Inc.,* 1946. *Pp.* 209. $3.

This book is supposed to contain "All the vast fund of practical facts about poisons . . . arranged most skillfully for instant reference." It was "originally written for police, investigators and peace officers" but the authors believe it will "be of value also to physicians, nurses, chemists and pharmacists" and "even be valuable in the home."

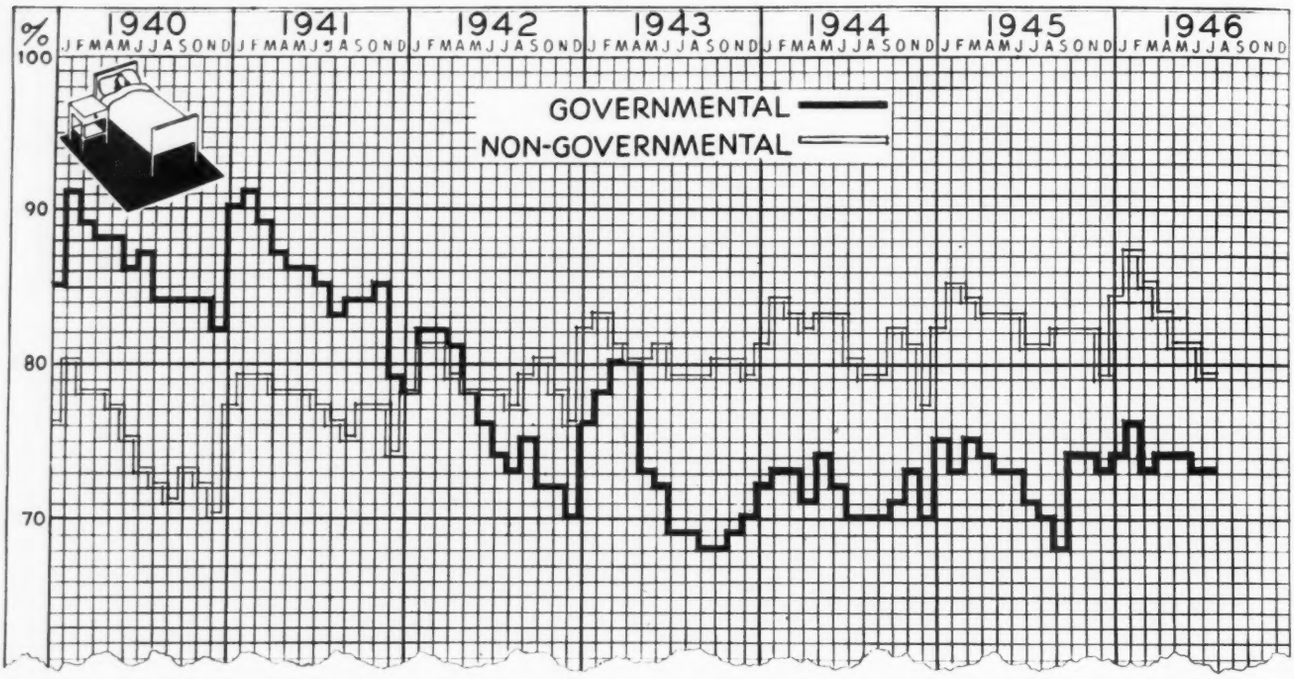
It is unfortunate that the authors attempted to reach such a large audience. As a result they have fallen short of presenting to any one segment the necessary facts in the best possible style. If there had been concentration on the needs of the police officer, much unnecessary material would have been omitted and the volume would be less confusing and boring for these men and women. As it is, the book will be difficult for the medically untrained to follow and inadequate for those with medical training.

Ninety poisons are listed in the index. There are seven chapters concerned with poison investigation, basic information for the investigator, special properties of poisons, emergency information for immediate reference, industrial hazards, poisoning from foods, plants, snakes and spiders, and special technics. Also included are an appendix and an index.

There are many faults to find but to choose some for emphasis is difficult, as their importance will vary with the training of the reader. For example, the police officer may not care if he learns that some of the uses attributed to a few drugs are incorrect, but the physician would not be happy to see statements to the effect that phenol is used in the control of diarrhea, and that chloroform has usefulness in the treatment of diarrhea, sea-sickness and hiccoughs. A number of agents are included which are probably seldom encountered by the police officer; for example, aconite and apomorphine.

If this book is revised to be suitable for a select group of readers, it could be a useful volume. As it is, most of the usefulness is buried under unnecessary data, some of which are erroneous and some of which are misleading in their presentation. Perhaps consultation with a medical or toxicologic authority is suggested when the revision is undertaken.—AUSTIN E. SMITH, M.D.

Occupancy of Voluntary Hospitals Drops Slightly



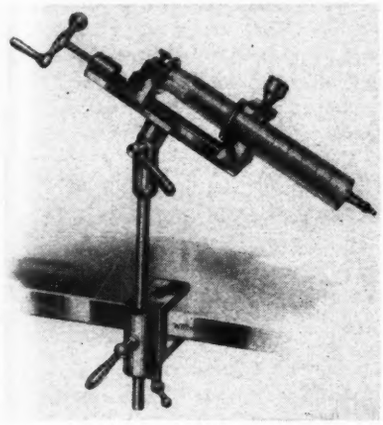
Occupancy of nongovernmental hospitals reporting to the Occupancy Chart was 79.4 per cent of capacity for the month of July, down 1 per cent from the previous month. Governmental hospitals reporting were 77.9 per cent occupied, slightly higher than in June.

Construction reported for the latest period reached a total of $61,937,950, 15 per cent more than in any previous period this year. Construction total for the year to date is $220,017,788, or 30 per cent higher than building reported for the same period last year. Of 57 jobs reporting construction costs, 22 were new hospitals costing $40,950,000, or an average of about $1,800,000 for each project. Thirty-three additions were reported totaling $10,550,000; and the one nurses' home reported will cost $1,400,000.

What's New for Hospitals

SEPTEMBER 1946 SUPPLEMENT TO THE MODERN HOSPITAL

Irvin Sodium Pentothal Injector



The Irvin Sodium Pentothal Injector is a convenient and satisfactory device for the administration of this general anesthetic. The single instrument is built to hold any size syringe which may be inserted or replaced in a few seconds. The spiral screw feed permits constant, gradual injection of the fluid without the possibility of erratic movement. A skip-thread safety device precludes the possibility of breakage of the syringe through undue pressure after the limit of travel of the syringe piston has been reached.

The entire impeller unit is chrome plated so that it can be sterilized without damage to any parts. The unit is mounted on a swivel bracket which is adjustable for height. **The Max Wocher & Son Co., Dept. MH, 609 College St., Cincinnati 2, Ohio. (Key No. 3229)**

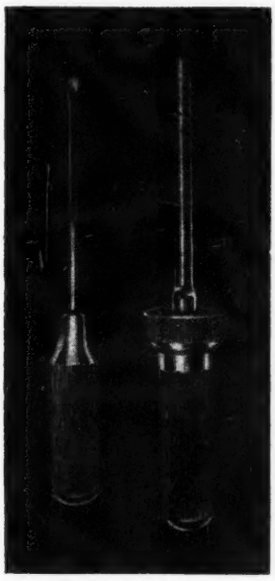
X-Ray Film Identifier

The new Chamberlain X-Ray Film Identifier is a device designed primarily to expedite the handling of x-ray photographic negatives. It records pertinent data concerning the individual patient and his case on a corner of the x-ray negative and eliminates the double system of filing data and film separately.

A table-mounted reduction printer, the instrument reduces 2 by 6 inches sections of data cards to one-half that size and makes additional exposures on corners of separate undeveloped x-ray negatives. Besides providing data, the unit gives a uniform, electrically-regulated exposure for judging the comparative quality of the entire negative. The identifier is 2⅛ inches high, 13 inches long and 8¾ inches wide. **Fairchild Camera & Instrument Corp., Dept. MH, Jamaica, N. Y. (Key No. 3239)**

DePuy Orthopedic Screw Driver

An ingenious new orthopedic screw driver, the use of which prevents the possibility of dropping a screw, has been developed by DePuy. The instrument is so designed that by pressure on the handle, the end of the screw driver opens and any desired size of screw can be picked up and gripped firmly. A turn of the corrugated handle, which is made by a simple movement of the thumb, tightens the mechanism so that the screw becomes almost a part of the instrument and the screwing process is accomplished without the possibility of slipping or loss of alignment of the screw once it is started through the screw plate into the bone. A simple thumb movement releases the instrument when the screw is firmly embedded and



only the final tightening need be done with the ordinary blade type of screw driver.

This new device can, of course, be sterilized with the other surgical instruments. The blade is of stainless steel, the special aluminum handle makes it light in weight and the design makes it easy and simple to use. **DePuy Mfg. Co., Dept. MH, Warsaw, Ind. (Key No. 3146)**

Plastic Hub Needle

The Albalon needle is a hypodermic needle with a white plastic nylon hub. The needle itself is of stainless steel, bevelled to pierce cleanly. The plastic hub withstands all commonly used methods of sterilizing and eliminates freezing of hub and syringe tip, thus tending to reduce breakage. Leakage around the syringe tip is also minimized by the elastic qualities of the plastic hub. **J. Bishop & Co., Dept. MH, Malvern, Pa. (Key No. 3198)**

Fortified Baby Food

Formulac is a new baby food fortified with sufficient vitamins and minerals to meet the nutritional needs of infants without supplementary administration. A reduced milk in liquid form, the new product lessens the possibilities of error in formulas requiring vitamins and minerals and has proved satisfactory in promoting infant growth and development. **National Dairy Co., Inc., Dept. MH, 230 Park Ave., New York 17. (Key No. 3110)**

Adams Desk Viewer

The Adams Desk Viewer is designed for viewing 2 by 2 inch Kodachromes and strip film up to 2½ inches wide. It should prove useful in the laboratory, the classroom and for individual study. With the viewer, no projector, screen or darkened room is necessary.

The viewer has a focusing eyepiece with locking knob which magnifies 2½ times, an accessory film carrier which is interchangeable with the slide carrier and has a die-cast aluminum housing with rubber feet to prevent scratching. The unit operates on either A.C. or D.C.

Clay-Adams Co., Inc., Dept. MH, 44 E. 23rd St., New York 10. (Key No. 3230)

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Reliance Solvent

A new solvent especially prepared for surgical use has been announced. It is a fast, safe and efficient cleanser for instruments and sundries which saves both time and effort. This soapless cleanser is designed for use on all metal instruments, rubber goods, glassware, enamelware and aluminum. It dissolves blood and tissue almost instantly and is designed to be equally effective in hard and soft water. **V. Mueller & Co., Dept. MH, 408 S. Honore St., Chicago 12. (Key No. 3227)**

Airkem Evapatrol Unit

Odor control in areas too large to be satisfactorily served by the Airkem bottle and wick, can now be assured with the use of the Evapatrol System. Consisting of a reservoir of Airkem, the deodorizing and air freshening element, with a pump, a regulator and a vaporizer, the new system can be attached to any type of air conditioning system or unit. The chemical deodorizing agent is pumped into the vaporizer, mixing with and freshening the conditioned air before it is recirculated. A portable Evapatrol unit is available for use in areas not equipped with air conditioning.

Maintenance of the system is simple, requiring only the refilling of the reservoir at intervals and changing the cartridge as needed. **W. H. Wheeler, Inc., Dept. MH, 7 E. 47th St., New York 17. (Key No. 3156)**

Insulation Resistance Tester

A handy instrument for detecting and preventing insulation failures is provided in the new Ideal Insulation Resistance Tester. It can be used for checking many types of A.C. and D.C. electric equipment, is entirely self-contained and is ready for instant use anywhere. This should prove of value to the maintenance department of the hospital. **Ideal Industries, Inc., Dept. MH, 4019 Park Ave., Sycamore, Ill. (Key No. 3193)**

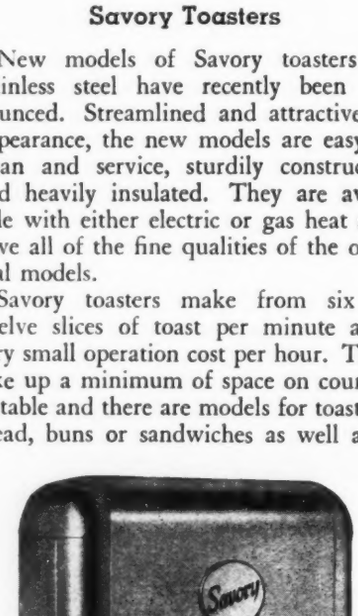
Window Filter

A combination filter and ventilator in a single unit, for use at window openings, has been announced under the name "Badgaire" Window Filter. Made of lightweight, sturdy aluminum with a special filter of wire mesh, the unit is rustproof and weatherproof. It is designed to admit fresh air while stopping dirt, soot and some pollens. Rubber gaskets on top, bottom and sides provide an air seal and sliding extension wings at either end with convenient holding knobs make the filter easy to insert. It is so designed as to prevent rain or snow from entering a room. The unit is 6 inches high and will fit windows from 22 to 40 inches wide. **Badger Corp., Dept. MH, E. Brown St., Milwaukee 12, Wis. (Key No. 3244)**

Savory Toasters

New models of Savory toasters in stainless steel have recently been announced. Streamlined and attractive in appearance, the new models are easy to clean and service, sturdily constructed and heavily insulated. They are available with either electric or gas heat and have all of the fine qualities of the original models.

Savory toasters make from six to twelve slices of toast per minute at a very small operation cost per hour. They take up a minimum of space on counter or table and there are models for toasting bread, buns or sandwiches as well as a



model for warming rolls. **Savory Equipment, Inc., Dept. MH, 120 Pacific St., Newark 5, N. J. (Key No. 3209)**

Folding Utility Table

A small folding utility table, light weight and sturdy, which should serve a number of purposes in the hospital, has just been announced. Extremely compact when folded, this Model WV table has an automatic action in open and closing, is very rigid and measures 26½ by 14¾ inches in size, 26½ inches high. The table is available in brown mahogany or honey maple finish. **Howe Folding Furniture, Inc., Dept. MH, 1 Park Ave., New York 17. (Key No. 3197)**

Armstrong's Accoflor

A new low cost, durable yet attractive floor has been developed by Armstrong Cork Company for locations receiving hard usage. It is recommended for use in hospital cafeterias, canteens, corridors, storerooms and locker rooms.

Of resilient yet tough mastic composition bonded to an asphalt saturated felt backing, Armstrong's Accoflor is long wearing, quiet and restful underfoot. Cuts and indentations normally smooth out under regular use because of its thermoplastic qualities. **Armstrong Cork Co., Dept. MH, Lancaster, Pa. (Key No. 3228)**

Odorless Bactericide

Hyamine 1622 is a new bactericide which is highly effective yet completely odorless. This quaternary ammonium compound is designed for sanitizing purposes and for drugs as well. Solutions containing Hyamine 1622, left standing in either open or closed containers, lose none of their original effectiveness but rather gain in disinfectant strength.

Hyamine 1622 is a white, crystalline powder, readily soluble in water. It is stable, non-irritating, nonflammable, possesses low toxicity to warm blooded animals and does not injure fabrics, metals or paint surfaces. Dilution results in a clear, colorless, odorless solution. **Rohm & Haas Co., Dept. MH, 222 W. Washington Square, Philadelphia, Pa. (Key No. 3248)**

Hand Lotion Dispenser

With the constant necessity for hand washing among hospital personnel and the drying of the skin which results, a new dispenser for hand lotion which has recently been announced should prove valuable in every utility room, washroom and other location where hands are washed. The use of this dispenser, where one push of the lever releases a measured quantity of lotion, just enough for each hand so that there is no waste, should save considerable time over the use of a lotion bottle and, in addition, should be more sanitary.

The dispenser is so designed that there is no drip or leak of lotion, and it has stainless steel internal parts which will not discolor or separate the lotion. The marbelized plastic body has a matching glass globe. The lock cap fastens it into the stainless steel top and the whole is affixed to the wall with concealed fastenings which are tamperproof. **Bobrick Mfg. Corp., Dept. MH, 2619 Santa Fe Ave., Los Angeles 11, Calif. (Key. No. 3201)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Rubber Cushions

Two new items molded from a newly developed rubber substance known as "Guard-Foam" have been announced by Guardian Latex Products Company. These are the Invalid-Eze Ring and the Chair-Eze Cushion. The new material conforms to body contours instantly and encourages complete relaxation in any position. It is antiseptic, dust and dirt proof, non-allergic and will not sag, pack or harden.

The Invalid-Eze Rings are available in two sizes as are also the Chair-Eze Cushions. Both ring and cushion are protected by a Plasto-Lyte cover that is water, acid and stain proof. **Guardian Latex Products Co., Dept. MH, 3809 Eagle Rock Blvd., Los Angeles 41, Calif. (Key No. 3234)**

Magnalite

The new Magnalite is a visual aid combining magnification with illumination in a single unit. Extreme flexibility and fingertip control are accomplished by means of a floating arm which supports the lens and lens mounting. The light can be adjusted to various positions by moving the working head without locking or clamping. Because the unit is self supporting in all positions, both hands of the operator are free. The light is soft and cool, causing the patient no discomfort and the location of the tubes eliminates glare for the operator. A broad field of vision is provided by the 5 inch optically ground magnifier.

The unit is sturdy and built for long service. Both floor and table mountings are available in two finishes.
The Haas Corp., Dept. MH, Mendon, Mich. (Key No. 3235)

Niagara Aero-Pass Condenser

A new device for the most economical operation of refrigeration machinery has been developed. Known as the Niagara Aero-Pass Condenser, the unit constantly produces, under automatic control, the lowest practicable head pressures at the compressor. The unit is designed for automatic year-round operation and to provide savings in the cost of operating power in the refrigerating system. **Niagara Blower Co., Dept. MH, 6 E. 45th St., New York 17. (Key No. 3236)**

Small Steam Trap

An ultra small steam trap has been developed for use with instrument sterilizers, water stills, plate warmers, coffee urns and other small steam heated equipment. The new thermostatic trap is only 2⅞ inches high, 1 inch center to face of inlet and weighs 12 ounces. Known as Sarco No. 10, the new trap is equipped with Sarco helically corrugated bronze bellows, brass body and renewable valve head and seat of stainless steel. The trap can also be used as a compact, high pressure thermostatic air vent. **Sarco Co., Inc., Dept. MH, 475 Fifth Ave., New York 17. (Key No. 3238)**

Colored Aluminum Vases

A new line of flower vases, made of fluted, unbreakable aluminum, has been developed for hospital use. Available in five brilliant, cheerful colors, in addition to black, silver and gold, the vases contribute to the cheerfulness of the patient's room. The colors are permanently impregnated on the metal, both inside and out, and the vases do not dent or chip because of being made of heavy gauge fluted aluminum. **American Medical Specialties Co., Dept. MH, 12 E. 12th St., New York 3. (Key No. 3243)**

Perma-Plastix Paint

A plastic paint designed for one coat application was developed early in the war and now is being put on the market. Known as Perma Plastix, the product is available in various colors for use wherever paint is needed, or as a clear, transparent coating. The colors are nonfading, the product leaves no brush marks and dries with a smooth, glossy coat. It is nonporous and stain resistant, does not peel, chip or crack and dries in 30 minutes. It is washable and long wearing and is available in 30 colors. **Arman Chemical Co., Dept. MH, 154 Nassau St., New York 7. (Key No. 3241)**

Steam Cleaning Product

A new liquid compound, which is water soluble and possesses the quality of not clogging equipment, has been developed for use in steam cleaning. The compound has a high alkalinity and will remove grease, oil and grime accumulations from the kind of surfaces and materials on which steam cleaning is employed. Being liquid, the solution need not be premixed but is poured with the water, in correct proportion, into the equipment tank. Use of this new liquid should clean the steam cleaning equipment itself. **The Penetone Co., Dept. MH., Tenafly, N. J. (Key No. 3206)**

PHARMACEUTICALS

Oxycel

Oxycel is an absorbable hemostatic oxidized cellulose prepared from various materials, such as gauze or cotton, by a special process of oxidation which converts unoxidized cellulose into polyanhydroglucuronic acid, an absorbable hemostatic chemical.

Supplied as individual sterile pads, Oxycel effects prompt hemostasis when applied to oozing surfaces and when left in contact with incised tissues is readily absorbable. It is used in various surgical procedures by direct application. When used within incised organs wounds may be closed without drainage. It can be used alone or as a carrier for Thrombin, Topical. The product is supplied in individual glass vials each containing one sterile pad in packages of 12. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 3251)**

Zymacap

A new capsule for vitamin therapy is announced as Zymacap. A high potency multivitamin preparation for use in multivitamin deficiencies, Zymacap is a soft elastic capsule containing a large dosage of vitamins A, D and C and the B complex. It is available in bottles of 24 and 100 capsules. **The Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 3214)**

Influenza Virus Vaccine

Influenza Virus Vaccine, Types A and B, is now available through Squibb. A sterile, refined and concentrated suspension of influenza virus prepared by the centrifugation method, the vaccine consists of 50 per cent Type A virus and 50 per cent Type B virus as these are the only known etiologic types of influenza. The product is supplied in 1 cc. and 10 cc. vials. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 3125)**

Crystalline Sodium Penicillin

Sodium penicillin in crystalline form, which is heat stable, thus eliminating the need for refrigeration, is now available. A special crystallization process in the final production stage of the sodium salt of penicillin makes the new form possible. Potency ranges from 1400 to 1500 units per mg. and the new product is white in color and odorless. The new form eliminates problems of transportation and storage. **Commercial Solvents Corp., Dept. MH, Terre Haute, Ind. (Key No. 3159)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

RECENT CATALOGS AND BOOKLETS

• A new recipe book featuring the use of **Stox Granulated Bouillon** for flavoring cocktails, entrees, salads and miscellaneous dishes has been issued by Standard Brands, Inc., 595 Madison Ave., New York 22. **(Key No. 3262)**

• An attractive and comprehensive catalog on **"Silex Glass Coffee Makers and Duolectric Steam Iron"** has been received from The Silex Co., Hartford 2, Conn. **(Key No. 3256)**

• Clinical data including reports of use of **Progesterone** are given in a booklet on this product issued by Eli Lilly & Co., Indianapolis 6, Ind. **(Key No. 3263)**

• **Bulletin 46-50** describes the complete line of **ADSCO Strainers and Separators** for steam, air or gas service. They are designed for easy access for removing foreign matter and the screens or baskets are furnished in various metals, depending on service conditions. The bulletin is published by American District Steam Co., North Tonawanda, N. Y. **(Key No. 3268)**

• The beauty and utility of Marlite wall paneling for new building and modernization are stressed in the new **1946 Marlite Catalog** recently issued by Marsh Wall Products, Inc., Dover, Ohio. Color as well as black and white photographs of Marlite installations are used to indicate the effectiveness of this versatile product. **(Key No. 3252)**

• A new booklet on the **Pandex Medical X-Ray Table,** which carries illustrations showing how this single tube unit produces improved radiographic results, has been published by Westinghouse Electric Corp., 306 Fourth Ave., Pittsburgh 30, Pa. Available accessories for the Pandex are listed in the booklet and the pages, "Facts at a Glance," give technical information and other details of interest. **(Key No. 3223)**

• The new **LCN Door Closer Catalog** features the importance of concealing operating devices such as door closers where appearance is a vital factor. Attractively made up, the catalog contains photographs showing the advantages of the concealed type of door closer with skeleton drawings indicating the mechanism. It has been published by Norton Lasier Co., 466 W. Superior St., Chicago 10. **(Key No. 3261)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 3110 Fortified Baby Food
- ☐ 3125 Influenza Virus Vaccine
- ☐ 3146 DePuy Orthopedic Screw Driver
- ☐ 3156 Airkem Evapatrol Unit
- ☐ 3159 Crystalline Sodium Penicillin
- ☐ 3193 Insulation Resistance Tester
- ☐ 3197 Folding Utility Table
- ☐ 3198 Plastic Hub Needle
- ☐ 3201 Hand Lotion Dispenser
- ☐ 3206 Steam Cleaning Product
- ☐ 3209 Savory Toasters
- ☐ 3214 Zymacap
- ☐ 3223 Pandex Medical X-Ray Table
- ☐ 3227 Reliance Solvent
- ☐ 3228 Armstrong's Accoflor
- ☐ 3229 Irvin Sodium Pentothal Injector
- ☐ 3230 Adams Desk Viewer
- ☐ 3234 Rubber Cushions
- ☐ 3235 Magnalite
- ☐ 3236 Niagara Aero-Pass Condenser
- ☐ 3238 Small Steam Trap
- ☐ 3239 X-Ray Film Identifier
- ☐ 3241 Perma-Plastix Paint
- ☐ 3243 Colored Aluminum Vases
- ☐ 3244 Window Filter
- ☐ 3248 Odorless Bactericide
- ☐ 3251 Oxycel
- ☐ 3252 1946 Marlite Catalog
- ☐ 3256 "Silex Glass Coffee Makers"
- ☐ 3261 LCN Door Closer Catalog
- ☐ 3262 Stox Granulated Bouillon
- ☐ 3263 Progesterone
- ☐ 3268 ADSCO Strainers and Separators

I should also like to have information on the following products

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

Manufacturers' Plant News

The American Hospital Supply Corp., Merchandise Mart, Chicago 54, announces the opening of complete warehouse and office facilities at 191-199 Marietta St. N. W., Atlanta 3, Ga., to serve the southern district. **(Key No. 3270)**

As a part of its expansion program, the **Celotex Corporation of Chicago** has acquired the Weaver-Wall Company of Cleveland, Ohio, manufacturers of asphalt shingles, roofing and siding products. **(Key No. 3271)**

John Sexton & Co., Chicago, has purchased the six-story Sanitary Building located on Northern Blvd. at Queen's Plaza at the east approach to the 59th St. bridge. This new building, with exceptional transportation facilities, will serve as its base of operations for the eastern Atlantic and New England states. **(Key No. 3272)**

Effective Sept. 1st, **Rosemary Sales,** now a division of Simmons Company, will be known as Simtex Mills. In addition to the main office at 40 Worth St., New York City, Simtex Mills have offices in the Merchandise Mart, Chicago, and at 819 Santee St., Los Angeles. The new division will distribute, under the newly-designed Simtex label, the same lines of merchandise handled by Rosemary. **(Key No. 3273)**

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